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# JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES

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ORIGINAL COMMUNICATIONS.

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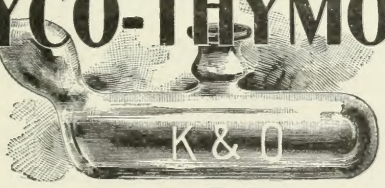


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JOURNAL OF
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## Original Communications.

# A DISCUSSION OF THE OPERATIVE TREATMENT OF PROSTATIC HYPERTROPHY; WITH THE PRESENTATION OF SPECIMENS AND MODELS BEARING ON THE SUBJECT.

BY BRANSFORD LEWIS, M.D.,
St. Louis.
Professor of Genito-Urinary Surgery in Marion-Sims-Beaumont College of Medicine; Consultant in Genito-Urinary Surgery to the City Hospital, Female Hospital, Rebekah Hospital, St. Mary's Infirmary, etc.

WHILE the surgery of the prostate has made wonderful strides of real progress within the past fifteen years; while the ingenuity and originality of members of our profession have been in the highest degree commendable, and have placed us, as well as humanity in general, in the position of owing them a debt of gratitude for their work in this line; while case after case of hypertrophied prostate is now operated upon with a large proportion of cures, and a still larger proportion of benefits as a result—it must still be admitted that there are numerous cases who are operated upon without either benefit or cure; and there are other cases who might be relieved by operation but are denied that advantage and are allowed to go through the balance of their miserable lives suffering from the various painful effects of that harassing malady; and still others are operated upon who do not need operation, who might be given an equal amount of benefit by less heroic and less radical methods of treatment. Moreover, if we look over the literature of this subject we find a well-marked tendency of operators to follow in a certain beaten

track, making use of some one operation only, that happens to suit their fancy or happens to be the product of their own planning.

This being the case, it can hardly be said that the profession stands in a position above criticism in these several respects; that it is either sufficiently unbiased to make an unprejudiced choice between the several operative methods in vogue, or has acquired sufficient ability to make the differential diagnosis of the case at hand that should determine the choice. It seems hardly possible that any one of the numerous measures could exactly fit the needs of all cases, varying, as the cases do, in respect to general and local conditions, age, vigor, character and form of growth, complications, etc.

To illustrate my position, I wish to call your attention to a few points in the histories of four cases with which I have been personally acquainted; and to submit for your inspection certain specimens and models of hypertrophied prostate bearing on the subject.

*Case I.*—A patient, aged 47 years, whom I saw in 1897, with my friend, Dr. H. M. Pierce, was a sufferer from a large number of the ills of prostatic obstruction. His debility was so great that the question of cancer, instead of hypertrophy, arose in my early investigation of the case. It was in the developmental period of Freudenberg's modification of the Bottini operation. I carried out this procedure, timidly, it must be confessed, in two successive sittings; and gained nothing more than some temporary increase in the ability of the patient in voluntary urination and in toning up his general condition. Although the electro-incisions incidentally did no harm, they did no good, and they had to be acknowledged as failures. Realizing this, I advocated a supra-pubic incision but could not get the patient's consent to an additional operation. Later, he reconsidered this determination, his objections melting away under the magnetic influence and persuasive powers of my friend, Dr. Graves, who made the supra-pubic opening, removed a growth projecting from the posterior commissure, and definitely cured the case. I am informed that the obstructing portion was somewhat pedunculated in form; and showed the marks of my cauterizer in being perforated through its middle.

*Case II.*—V. S., æt. 65 years, came to my clinic in October, 1901, suffering from various effects of prostatic obstruction, chief among which was complete and absolute inability to urinate voluntarily, and this, notwithstanding the fact that perineal prostatectomy had been done on him six months before (on June 6th, 1901) by an acknowledged authority in this mode of operating. The complete retention, relieved only by the regular passage of the catheter, had existed, the patient said, from the time of the withdrawal of the perineal drainage

tube, seven days after the operation. A perineal fistula still existed, from the same procedure.

Here was a case of complete failure of relief after removal of the prostate by an operator whose ability and experience cannot be put into question.

My cystoscopic examination seemed to reveal a projection from the posterior commissure, hanging somewhat into the bladder. With a doubt in my mind as to its probable efficacy in the case, which doubt I expressed to the class before whom I operated, on November 20, 1901, I made one posterior incision, 3 centimeters in length, with the Freudenberg incisor. Because of the absence of prostatic tissue, on account of the previous operation, it was evident that care must be observed not to burn into perineal structures. No hemorrhage resulted; cocaine anesthesia, secured with my urethral tablet-depositor, was so complete that the patient declared that there was no more pain than there was from an ordinary catheterism. He remained in the hospital three or four days, and was then about, as usual. Result, possibility of voluntary urination, and reduction of the complete retention to seven ounces of residual urine. One month later, the same operation was repeated, with no more trouble to the patient; and the net result was a further reduction of the residual urine to about four ounces, together with increased freedom in voluntary urination. This not being satisfactory to me—although a marked improvement over his condition for the previous five or six years—it seemed advisable to open supra-pubically, which I did before the class on January 8th, 1902. I found the condition represented by the clay model herewith presented (Fig. 1). A collarette of fibro-mucoid tissue completely surrounded the urethral orifice, and in just the position to fall together in a valvular manner and shut off the egress of urine when attempts at voluntary urination were made. The more marked the contraction, the tighter would the valve be closed. My posterior cautery incision was there, as shown in the model, but it had only bisected the posterior segment of the collar, the flaps of which could still fall together and interfere markedly with the outflow of urine—although the groove thus made would probably allow of the leakage through it of a part of the urine. This accounted for the improvement noted after each of the electro-incisions (reduction in the residual urine at first to seven, then to four ounces); and also for the failure of the incision to give *complete* relief to the case.

Through the supra-pubic opening, with a Paquelin cautery I burned off the whole of the projecting mass, accentuating the cauterization on the posterior aspect, to secure as low a level as possible;

nevertheless a considerable depression was still left in the bas fond, as I did not wish to open the prostatic urethra to secure an absolutely

FIG. 1.

*Prostatic hypertrophy. Model of Schneider case. Lateral lobes removed 1901. Groove by Bottini through collar of fibromucoid tissue about urethral orifice. Complete relief from suprapubic operation.*

"low level," flush with the bottom of the bas fond. My chief object was to *remove the obstruction*, which was done in the manner de-

scribed. Nothing was done bearing directly on the perineal fistula. It was considered that, with clearing up of the outlet, this would take care of itself. The bladder was drained supra-pubically for eight days. After the removal of the tube, and even before the supra-pubic wound was closed, the bladder was able to expel in a good stream through the urethra a part of the urine or the irrigation fluid. Since the closure of the wound, he has urinated properly and regularly, in what he esteems a very delightful stream. He can irrigate his bladder without the aid of the catheter; in fact, the catheter is now never used except for the purpose of testing the amount of residual urine, which has been reduced to one-half or three-fourths of an ounce. The frequency of urination is about normal (six or seven times in twenty-four hours). The patient has been able to resume his occupation of carpentering after an interruption of one year. He relates that previous to the prostatectomy, he had been forced to use the catheter regularly for nearly eight years, carrying it in his pocket for that purpose (from March, 1894, to November, 1901).

*Case III.*—W. D. æt. 65 years, was turned over to my care at the City Hospital, by my friend, Dr. Nietert, who, with his internes at that time, is familiar with the subsequent developments.

The patient had suffered from troubles connected with urination for four or five years previously. His general health and strength were markedly reduced, so that he was very feeble, looking much older than he really was. He was passing urine about thirty-five times in twenty-four hours, as often at night as in the day time, harassing him with loss of sleep as well as much actual suffering. His urine was of light straw color, low specific gravity (1.010), and contained albumin and casts, indicative of involvement of the kidneys. Cystitis was present. Residual urine was about twenty-eight ounces. A metal catheter of ordinary curve was obstructed, while one of long prostatic curve went in easily. Because of the enfeebled condition of the patient, and the renal complication mentioned, a more radical operation than the Bottini was deemed dangerous; and it was considered necessary to undertake even that with the utmost caution. The Bottini was done on January 27, 1898, under cocaine anesthesia, only one (posterior) incision being made in order to avoid severity as much as possible. It was ten days afterwards before noticeable improvement began, but it was progressive thereafter, so that in a month he was urinating freely and in a good stream; and instead of thirty-five times in the twenty-four hours, it was only seven or eight times. The residuum had been reduced to about two ounces. The patient's general and renal conditions had both improved materially. I was desirous of showing him at the Medical

Society, to which he consented, with the request, however, that we wait until he could be operated on for a large inguinal hernia, of which he was the bearer. We waited. He was turned over to another consulting surgeon who operated for the hernia. The wound became infected, resulting in gangrene there and also in the intestines and lungs. His death soon after enabled me to get this specimen, which I show you. As is usual after maceration in alcohol, the tissues, have shrunk somewhat, so that they do not appear exactly as they did when fresh; but the moderate enlargement of the prostate is evident, likewise the groove posteriorly and to the right, made by the incisor. The depth of this groove is only evident when we appose the parts as they were before the incision was made, when the narrowing of the outlet is seen to be marked. Dr. Willard Bartlett, who made the post-mortem examination, made the following annotation regarding it: "The prostate shows both lateral lobes hypertrophied. The wound left by what the clinical history terms 'Bottini's operation,' is completely healed, leaving an orifice to the right of the median line which will easily admit an ordinary lead pencil into the prostatic urethra, and evidently furnished a free outlet for the urine." The obstructive condition in this case was a bar-formation at the posterior commissure; the incision had severed it and opened a groove through which the urine could pass with only slight impediment.

*Case IV.*—Mr. C. L., aet. 50, came to me four years ago (April 15, 1898), referred by my friend, Dr. Y. H. Bond. Although I did not learn of it until later, the patient had just received the advice from a genito-urinary surgeon to undergo an operation on account of hypertrophied prostate, for the relief of the symptoms of which he was then complaining, *i.e.*, frequency of urination, burning during the act, etc.; symptoms only moderate in intensity and in number. Examining, I found slight cystitis, a very small degree of enlargement of the prostate, which was soft to the feel, as if congested rather than hypertrophied; and *not a teaspoonful of residual urine*. In addition, there was glycosuria, which proved to be diabetes of moderate degree.

I gave the patient my diagnosis, as above indicated. He asked as to the advisability of an operation for his "hypertrophied prostate." I said that I perceived absolutely no reason for such a procedure, and expressed the belief that less heroic measures would suffice. This advice was accepted; I gave his bladder a few antiseptic irrigations, put him on a regimen for his diabetes; and for the four years since that time, that he has been under my care and observation, his urine has been clear, he has suffered not at all from bladder symptoms, and his

glycosuria has been only an occasional factor. The patient has never had another symptom referable to his "prostate."

Now, Mr. President, I would like to ask, what was the use of my making the electro-incision in Case I., that was cured by Dr. Graves by the suprapubic removal of the obstructing, pedunculated projection? Or what would have been the use in removing that patient's prostate, either by the perineal or the suprapubic route?

In Case II., what benefit was derived from the prostatectomy that was done? The patient declares that he had to use the catheter after it the same as he had done for six years before.

And, in Case III., at the City Hospital, what would have been the advantage of subjecting such a frail, enfeebled being to the dangerous accompaniments of prostatectomy, necessitating general anesthesia, inducing hemorrhage, inviting sepsis (which did occur in a subsequent herniotomy, from which death resulted), and necessitating prolonged drainage, confinement in bed, etc., when he could, as was proved, be completely relieved with the one electro-incision that was made—causing no bleeding, no debility, fever, or other bad effects? Conservatism should hold as good in this department of surgery as in any other; if a less serious operation suffices in a given case, why adopt a greater?

As to the fourth case cited, its lesson is self-evident. No operation of any kind was indicated. It might have made a good case for adding to statistics as another "success," but the patient has not brought himself to the belief that it is necessary for him to immolate himself in that way.

The chief lesson of these histories, I take it, is that certain cases of prostatic obstruction are amenable to certain kinds of treatment, while for others the same kind of treatment would be wholly inapplicable or inadequate. This teaching of the clinic is confirmed and explained when we have the opportunity to study the actual conditions present in a number of cases of hypertrophied prostate.

I wish to present for your inspection some specimens of hypertrophied prostates and some reproductions of other hypertrophied prostates, illustrating a number of the different forms of this condition, exactly as it occurs in life.

In model No. 2 we have an illustration of considerable enlargement of both lateral lobes and of the so-called median lobe, of pronounced type. The median enlargement is in the form of a globular tumor springing, in a pedunculated manner, from the posterior commissure of prostatic tissue—the posterior junction of the lateral lobes. It projects well into the bladder and, placed as it is, directly overhanging the urethral orifice, this tumor would fall in just the position to interrupt

the outward flow of urine, acting in the ball-and-socket manner that is so effectual in making obstruction. It is apparent that the obstruction

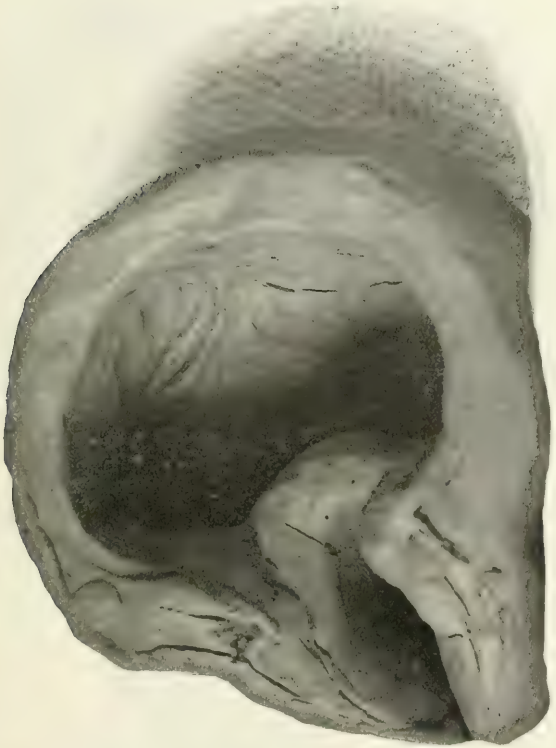
FIG. 2

*Prostatic hypertrophy. Bilateral enlargement with obstruction from pedunculated intravesical growth. Suprapubic removal, operation of choice.*

would be only to the current going outward; to the current or the catheter going inward, the tumor would gracefully back out of the way, permitting easy entrance. The median projection in this instance is in

the form of a globular mass or tumor, no effort at "bar" formation being present. The lateral lobes are about equally enlarged, but not so much

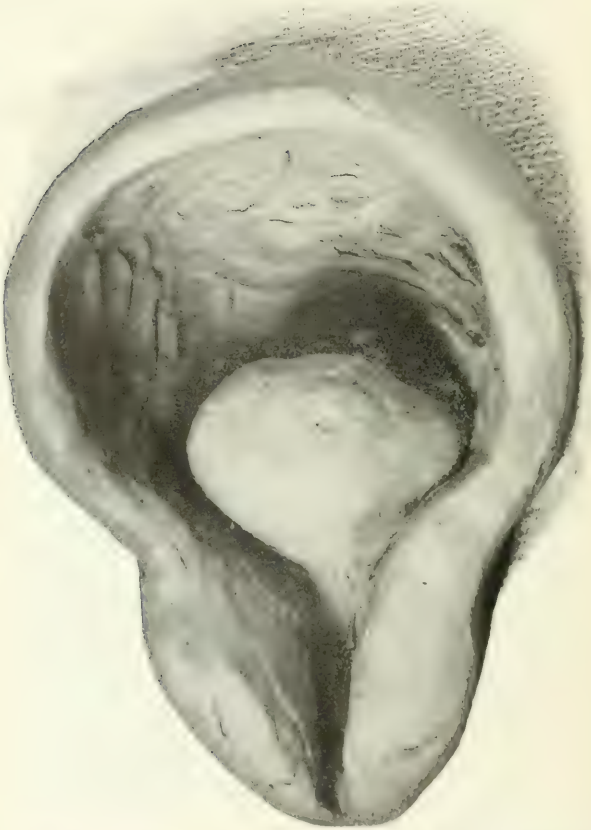
FIG. 3.



*Prostatic hypertrophy. Moderate enlargement lateral lobes; thick prostatic bar; deep bas fond. Marked curvature of urethra. Favorable for perineal prostatectomy.*

as to encroach on the caliber of the urethra nor to distort the latter into a narrow, tortuous slit, as is noticeable in certain cases. With the

FIG. 4.



*Prostatic hypertrophy. Enlargement of both lateral lobes, pedunculated medial intravesical tumor from posterior commissure. Suitable for suprapubic removal.*

median tumor out of the way, there is, apparently, nothing in this specimen that would cause interference with the outflow of urine.

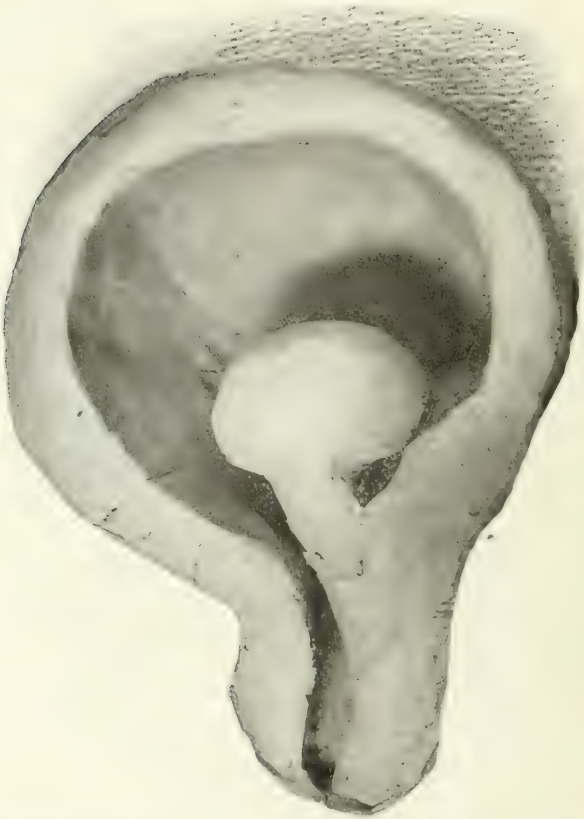
In specimen No. 3 we see greater enlargement of the two lateral lobes, which project into the bladder cavity; and their posterior extremities are joined together by a bridge of tissue, forming a bar between the bladder cavity and its outlet. The higher this bar or dam, the deeper the stagnating pool of urine behind it, and the harder for the bladder to contract sufficiently to push the urine over the dam—even if it were not already in a weakened condition from over-stretching and inflammation. Where the hypertrophy is as large as it is in this case, the very mass of tissue itself, standing in the way, tends to interfere with the natural process of contraction of the bladder. There is persistent collection of urine in the receptacle (the bas fond) behind the bar; the urine that escapes on voluntary effort is only the overflow; that which remains is called "residual" urine. It is, as Guyon has shown, in a receptive state for infection with microbes; so that, when in this condition, the introduction of an unclean catheter may change the clinical picture from one of simple retention to one of retention plus infection, inaugurating a new list of harassing symptoms. The right lobe, in this model, is distinctly larger than the left; and the thick median bar is heaped up more on the right side than the left.

Specimen No. 4 shows an exaggerated degree of median hypertrophy, in a tumor-like mass, much larger than in the second instance. It shows the division of the urethra into two channels as the prostatic urethra mounts the bar towards the bladder cavity. In such a condition a metal catheter would be deflected to one side or the other, if it passed in; or, if of ordinary curve, it would be stopped short by impinging against the face of the tumor. In this case there is no bar formation; the hypertrophy and the obstruction are both essentially median, the lateral lobes being only moderately enlarged and not in such a way as to encroach on the outlet.

Specimen No. 5 is taken from an illustration of Erichsen, showing a vertical section of pedunculated median outgrowth. It indicates beautifully the manner in which the median tumor may cause obstruction by ball-and-socket effect, and without regard to the size of the remainder of the prostate. The bladder contracts to expel its contents; the ball falls directly over the outlet, closing it more or less according to its shape and the accompanying conditions.

Specimen No. 6 is in sharp contrast to the previous ones, being an enormous, uniform hypertrophy of the prostate as a whole, both lobes projecting far into the bladder in great masses. But the inevitable median enlargement is also present, making the bridge of tissue between the lateral lobes. This bladder was proportionately dilated, and the backward pressure was indicated, also, by marked dilatation of both

FIG. 5.



*Prostatic hypertrophy. (Vertical section.) Pedunculated median intravesical growth from posterior commissure. Favorable for suprapubic removal.*

ureters and both kidneys. One peculiarity about the backward pressure in this case was that it came onto the ureter-openings from the direct pressure of the immense lobes hanging over them. The lobes practi-

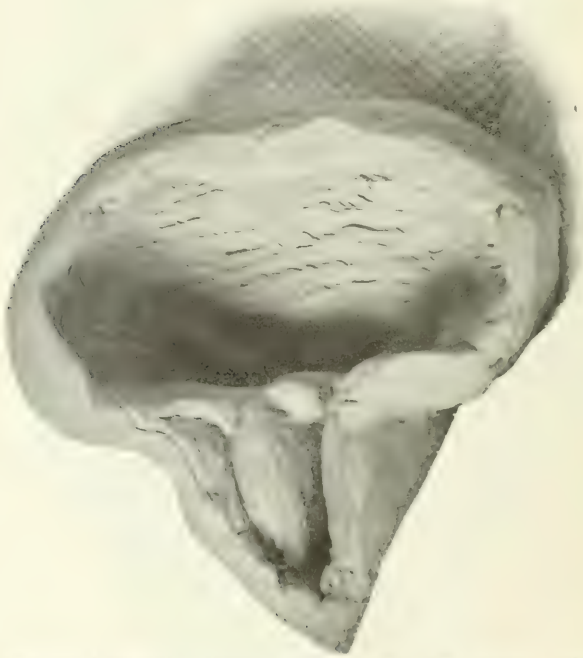
Fig. 6.

*Prostatic hypertrophy. Excessive enlargement of lateral and median lobes; direct pressure on both ureter openings producing dilatation of ureters and renal pelves. Favorable for combined suprapubic and perineal removal.*

cally filled out most of the space of the bas fond and rested on the ureter openings. I have never seen another instance of this kind.

Specimen No. 7 presents bilateral enlargement of the prostate, with a bar not so thick as the one in No. 3; and additionally, there is a nodule hanging over the urethral orifice from the upper margin of the right lobe. The right lobe is much more hypertrophied than the left.

FIG. 7

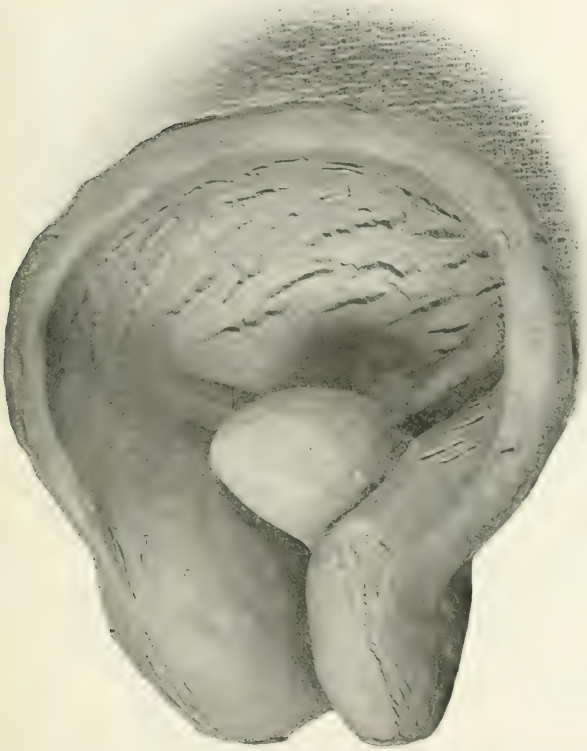


*Prostate hypertrophy. Lateral lobes equally enlarged. Thin central bar, with small nodule on right, deep bas fond. Favorable for Bottini, or perineal prostatectomy.*

The urethra curves deeply as it goes through the prostate, increasing its length, as well as its natural curve, while passing through that organ. By the pressing together of the two lateral lobes it is compressed into a slit-like channel. Altogether, the urine must have had a hard time

getting past the impediments presented in this case. That fact is attested in the depth of the bas fond behind the bar.

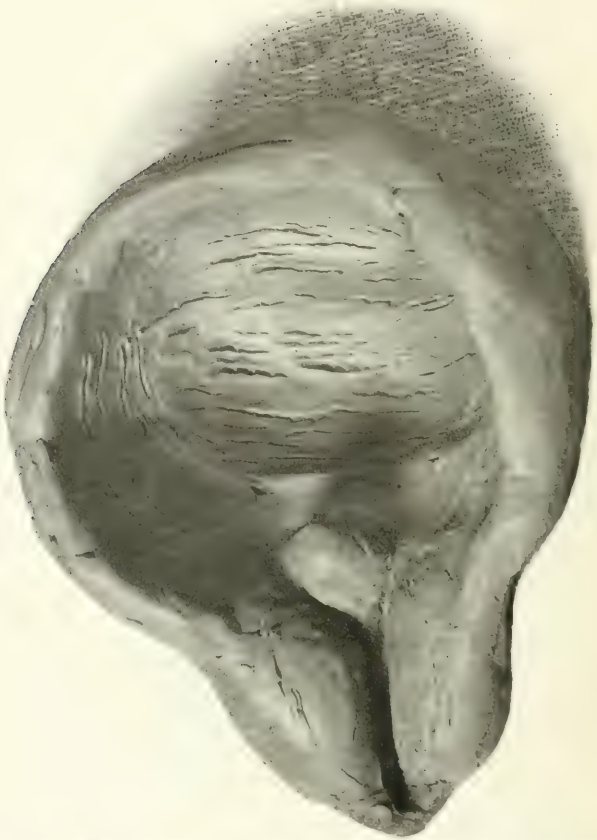
Fig. 8.



*Prostatic hypertrophy. Marked enlargement of both lateral lobes, and globular intravesical tumor from posterior commissure. Removal of tumor and both lobes required; best accomplished through perineal and, possibly, suprapubic combined routes. Bottini inappropriate and inadequate.*

Specimen No. 8 shows large, globular enlargements of the lateral lobes, marked compression of the urethra between them; and a large,

FIG. 9.

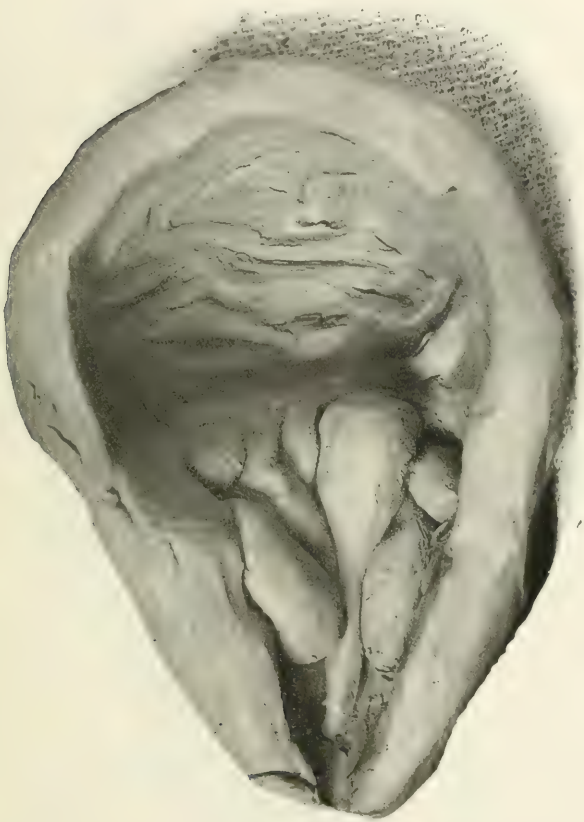


*Prostatic hypertrophy. Moderate enlargement lateral lobes. Pyramidal median projection causing a ball and socket effect. Suitable for suprapubic removal.*

round median tumor from the posterior commissure, overhanging the urethro-vesical orifice.

Specimen No. 9, modeled after a pathological preparation belonging to Dr. Broome, shows a very unusual shape in the median projection;

FIG. 10.



*Prostatic hypertrophy. Multiple adenomata projecting into prostatic urethra. Favorable for perineal removal. Bottini inappropriate and inadequate.*

it is pyramidal, and stands well into the bladder cavity. The lateral lobes are enlarged to only a moderate degree.

Specimen No. 10 shows a number of tumor-like masses (adenomata) pressing into the prostatic urethral cavity; and, although they

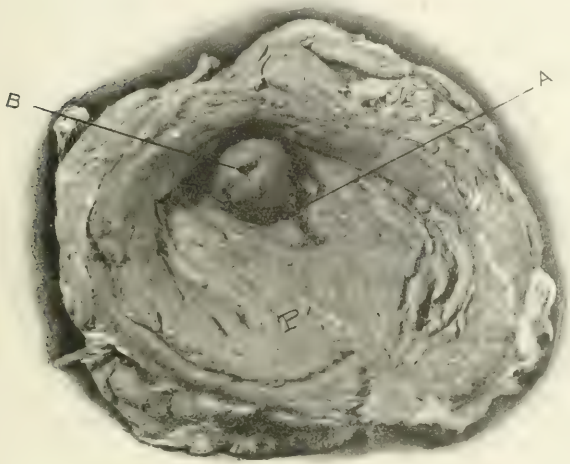
FIG. 11.

*Prostatic hypertrophy. Moderate enlargement of both lateral lobes, associated with early general atrophy in that respect. No operative treatment required. After Watson.*

have widened out that cavity, they have at the same time encroached on its space for carrying urine.

Speciment No. 11 shows a departure from the usual form of enlargement that, so far as my acquaintance goes, is almost uniques. The median tumor, instead of springing from the posterior commissure, hangs from the anterior one, jutting into the urethral orifice in such a

Fig. 12.




*Prostatic hypertrophy. Photo of unique specimen. Intravesical globular tumor springing from anterior commissure, falling backwards, obstructing outflow. A, urethral orifice. B, blind pocket in apex of tumor. P, posterior bladder wall. Suprapubic removal, operation of choice; inaccessible through perineal route; possible benefit from anterior Bottini incision.*

way as to effectually cut off the escape of urine. A perineal prostatectomy would be very liable to leave this tumor in its present position, working, as the operator must, from below, and at the same time endeavoring to avoid injury to the anterior urethral wall, as he usually does.

The main reliance in the Bottini operation is on the posterior incision. If made in a case like this, or if supplemented by two lateral incisions, or even an anterior one in addition, it would be doubtful if

any benefit would ensue. Certainly benefit would not come from the posterior or lateral incisions.

From these several specimens it is evident that, although the prostate has a pretty well-developed habit of enlarging in a certain *direction* (toward the bladder cavity), its *forms* of enlargement, and the several combinations of these, offer much variety.

In looking up the relative frequency of these various kinds of enlargements, I find that some form of median elevation is seldom absent. For instance, in Watson's review of 28 cases of prostatic hypertrophy there was only one case in which there was no median hypertrophy; in Sir Henry Thompson's analysis of 123 cases, it was absent in only 11 cases, and as I reviewed Moullin's tables of 140 operated cases I found that there were but 17 cases in which no mention of the median outgrowth was made in the records of the operator. It is evident, then, that median enlargement is nearly always present; it is absent in only about 8 per cent. of cases, taking an average of these three collections.

Examination of the same three sets of records will show that they may be divided as follows:

Median, with general enlargement,

(*a*) of one lateral lobe, 33.

(*b*) of both lateral lobes, 106.

Median without general enlargement,

(*a*) tumor-like projection, 46.

(*b*) bar or collar, 23.

To meet these several conditions in an operative way, there are a variety of methods. Classified under the avenue of approach, they may be divided into the suprapubic, the perineal, the combined perineo-suprapubic, and the urethral.

In some cases (specimens 1, 5, 9), the snipping off of a pedunculated tumor overhanging the urethral orifice is all that is needed to relieve the obstruction. A greater operation than this is not required; a lesser one is inadequate, and an electro-incision that simply bisects it, does no good.

Such a tumor is accessible and demonstrable through a suprapubic opening, through which route the operator can work to good advantage under direct observation, with ample light, using the actual cautery if necessary. There are several instances recorded in which operators working through a perineal opening failed to discover or to remove such a protuberance, and were unable to relieve the obstruction until a later, suprapubic, operation disclosed the reason. It is not difficult to understand how this may be, in a case, for instance, with long perineal distance, large lateral lobes, and tight, narrow urethra, with high implantation of the tumor.

On the other hand, there are certain cases in which there is short perineal distance, massive overgrowth of both lateral lobes, and either a sessile median enlargement or a thick bar formation, in which the perineal is the more favorable route for removal, following out the lines laid down by the later operators mentioned (omitting, however, the accessory suprapubic incision, either of the combined operations, or the incision into the space of Retzius as recommended by Bryson). Save in a few exceptional instances, the upper incisions, for the purpose of depressing the prostate into the perineal wound, are no longer necessary or advisable, the prostatic depressor of Ferguson supplying this need without the added opening. The rubber bulb of Syms has not proved a success, for several reasons.

TABULATION OF METHODS OF OPERATION ON THE HYPERTROPHIED PROSTATE.

| | | |
|---|---|---|
| Supra-pubic | Drainage | — Hunter McGuire, 1888. Permanent supra-pubic fistula. |
| | Prostatectomy | Belfield, 1886. Enucleation. Modified in 1899 by adding perineal boutonniere for drainage. |
| | | McGill, 1887. Enucleation, morcellement, exsection. |
| | | Freyer, 1901. Total enucleation of prostate in its "true" capsule; rectal counter-pressure; urethra left intact. |
| Perineal | Incision | — Reginald Harrison, 1887. Knife-incision and drainage. |
| | Electro-incision | — Wishard, 1890 and 1902; Chetwood, 1901. |
| | | Von Dittel, 1899. By coccygeo-perineal incision. |
| | Prostatectomy | Wishard, 1891. Intra-urethral incision and enucleation. |
| | | Pyle, 1892. Through semi-lunar incision. |
| | | Syms, 1901. With rubber bulb traction for depressing prostate. |
| | | Ferguson, 1902. With intra urethro-vesical prostatic depressor; subcapsular enucleation and morcellement. |
| | | J. B. Murphy, 1902. Prostatic depression with hooks. |
| Combined Perineo-prevesical | Prostatectomy | Fuller, 1895. Enucleation from above, counter-pressure against perineum; drainage above and below. |
| | | Nicoll, 1895. Perineal enucleation, counter-pressure from above through opened bladder; drainage through catheter retained in unopened urethra. |
| | | Alexander, 1896. Perineal enucleation, intra-urethral attack; counter-pressure from above through the opened bladder; drainage above and below. |
| | | Bryson, 1899. Perineal subcapsular enucleation; supra-pubic prevesical incision (not opening bladder) for counter-pressure; drainage below. |
| | | Syms, 1899. Perineal enucleation; counter-pressure through epicystic incision into peritoneum. |
| | | Guiteras, 1901. Supra-pubic enucleation, counter-pressure from finger in rectum; drainage above and below. |
| Urethral | Incision | Mercier, 1857. Buried knife. |
| | | Gouley, 1885. Buried knife. |
| | | Bottini, 1875. Electro-incision. |
| | | Freudenberg, 1897. Electro-incision with aseptic instrument provided with cooling apparatus. |

Some operators, while adopting incisions both below and above, make use of the upper one as the chief avenue for making the removal of prostatic tissue, using the lower one only for additional drainage (Belfield, Fuller, Guiteras).

While the older modes of doing suprapubic prostatectomy, as at first described by Belfield and Mercill, have practically been abandoned, Freyer in the British Medical Journal, February 1, 1902, describes a mode of taking out the whole of the prostate in two lateral halves, through a suprapubic incision, leaving the urethra unopened. He reports gratifying success with this method. In one case he removed a prostate weighing 10¼ ounces, with permanent relief. While this is true, from the studies of the specimens I have shown, and the statistics presented, it is questionable whether it is necessary or advisable to make complete prostatectomy. It has been shown that the obstruction comes, in nearly all cases, from either the posterior commissure or the lateral lobes or both, but very seldom from the anterior commissure; so why should this unoffending part be removed? Aside from this operation of Freyer, most of the methods produce only partial prostatectomy, leaving the anterior urethral wall and commissure intact—and it is particularly desirable that they be left intact, to make the nidus for the regenerated urethra. In the later perineal operations the floor of the urethra is ordinarily torn away.

While the Bottini electro-incision is not appropriate for all cases of prostatic obstruction, the same thing may be said with equal propriety regarding all the other operations for this condition. There is, I am convinced, a considerable place for this method in this field. Without here referring to the objections made to it by its opponents or to the advantages claimed for it by its advocates, it may be said that the especial forms of prostatic obstruction in which it will find the best application are those of the prostatic bar, or the sessile median hypertrophy, both of which are not unusual forms of the abnormality. Pedunculation of outgrowths, complete collar formation, and massive lateral lobes, are conditions not favoring success with this method. While in some cases of massive bar formation, as in specimen No. 6, an electro-incision would hardly be sufficient to make a good outlet for the urine, such an excessive development is very exceptional; and it will be even rarer as the operability of prostatic hypertrophy becomes more widely recognized. On the other hand, there are, doubtless, a number of cases of either bar or sessile median hypertrophy that undergo one or other of the modes of prostatectomy, with general anesthesia, hemorrhage, prolonged drainage, confinement to bed, etc., that might be permanently relieved by electro-incision, under local anesthesia, unaccompanied with bleeding, and not followed by the after effects of the major procedure. Many such cases *have* been cured by it, we know. If there have been many failures, we must attribute a large proportion of them to lack of making proper selection in applying the method.

Summing up the points favorable to the three operative procedures especially considered in this discussion, we have:

*Favorable for the supra-pubic route:*

1. General enlargement of the prostate, with extreme intra-vesical projection of the median or lateral lobes, diminishing their accessibility from the perineum.

2. Marked pedunculation of the intra-vesical tumors, with absence of obstruction from other sources.

*Favorable for the perineal route:*

1. General hypertrophy, involving the median and lateral lobes, without extreme intra-vesical projection.

2. Large or very thick bar formation; marked compression of the urethra between the enlarged lateral lobes.

3. Excessive development of the prostate in the direction of the rectum.

4. In most cases, where the patient is in good general condition and there is not a special indication favoring one of the other procedures.

*Favorable for the Bottini:*

1. Cases of extreme debility, unable to stand one of the severer operations.

2. Cases of bar or medium sessile obstruction, of not too great dimensions.

3. Incomplete collar formation.

4. Horwitz says it should be employed as a prophylatic against further obstructive hypertrophy, at the beginning of catheter-life.

Supra-pubic cystotomy for drainage only, is a palliative measure that has certain well-defined and highly advantageous features—not with reference to curing a case of prostatic obstruction, but for the purpose of improving conditions so that curative measures may be undertaken. It can be carried out under local (infiltration) anesthesia, without adding to the seriousness of the conditions; and the drainage that it affords may work wonders in the manner mentioned.

As a substitute for this incision, being even milder still in its effects, I would commend a method that I have carried out on one or two cases, as follows: Supra-pubic puncture with trocar and cannula; withdrawal of the trocar; insertion of a soft rubber catheter through the cannula into the bladder; withdrawal of the cannula, leaving the catheter retained in the bladder, and held in place by safety-pins and proper bandages. I drained one case for ten days in this manner and without ill effect.

*627 Century Building.*

# A CASE OF MYCOSIS FUNGOIDES.*

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THE following case is reported chiefly because of the facts that it was under observation of physicians for a period of 5 or 6 years, after appearance of subjective symptoms and was in hospital the last two months of patient's life. That microscopic examination of tissue removed from tumors was made at time of his entrance and a much more thorough post mortem examination was made than is ordinarily practicable—offering opportunities for study of progress of disease and results. And though there was abundant evidence of metastases, no specific organisms by microscopic or culture tests were found. The subject has been so very fully discussed in current dermatological literature within the last few years that no attempt is made to review the pathology further than showing the changing views and diversity of opinions of observers and reporters.

*Extract from Clinical Record.*—H. H. D., 33, married, entered U. of M. Hospital, Oct. 30, 1900 (after being under my care a few weeks). Occupations: Had been carpenter, keeper in prison, mail carrier and employee on R. W. Family history, negative as to parents. No history of specific or hereditary disease in family. Has two children, 12 and 4, in good health.

*Previous History.*—Digestion, normal, some headache. Has had rheumatism. Treated by numerous physicians for eczema in early stages of his disease.

*Present Condition.*—Appetite, excellent; digestion, good; bowels, regular; sleeps poorly; urine in large amount, but negative. Trouble with skin began six years ago on leg as a scaly condition of skin. January 1, 1898, tumors developed on wrist, arm, neck and forehead and nose. Feet very moist and always smelled badly, skin of feet cracked and exuded liquid. Location and description of lesions (see photo No. 2 taken about this time): face, head and neck covered by nodules of all sizes up to two inches, some smooth, others rough and ulcerating, and offensive in odor; nodules under each arm and legs, one on right arm, little finger of right hand removed a few weeks

* Read before the Ann Arbor Medical Club, April, 1902.

before on account of large nodules, stump healed kindly; hair began to fall five months ago, when the tumors started on the scalp.

Microscopic examination of tissue gave structure of growth as that of lymphosarcoma and microscopical diagnosis as general sarcomatosis of the skin.

The patient steadily grew worse and died from exhaustion January

FIG. 1.

*Taken two years before Fig. 2.*

10, 1901. He suffered last few days from bronchopneumonia, many of the tumors undergoing marked change in size and shape.

The patient was under the care of Dr. A. P. Biddle of Detroit, who reported the case to the Detroit Medical Society in latter part of 1898, published in January, 1900, in *The Physician and Surgeon.*

Dr. Biddle's report so fully describes the appearances of the prefungoid stage, as well as the early tumor stage, that I quote freely from his valuable paper:

(Photograph No. 1, taken by Dr. Biddle, August, 1900).—"He

presented in his early personal and family history nothing that would throw light upon the etiology of the disease from which he was suffering. He was well nourished, large, strong man, and his general health was excellent. He had been treated for two years by one physician and another for psoriasis, not an unnatural mistake as in the early and

FIG. 2.

*Figs. 2, 3 and 4 taken six months later than the first picture.*

prefungoid stage the disease in so many respects resembling psoriasis, as to be impossible of differentiation. The tumor stage had already set in, so that I knew the disease could not be psoriasis, though the body was profusely covered with a brownish red slightly elevated scaly eruption, in patches, mostly discrete, but sometimes confluent of a

variegated pattern, but with a tendency to irregular oval and gyrate figures, bearing some resemblance to psoriasis but differing from it in that the infiltration was not as deep, the individual patch not as red, the margin not as well defined, the scales not as white, the scaling not as profuse, and the itching decidedly more intense. The disease dated

FIG. 3.

back about four years, and was brought to the patient's notice by an excessive itching behind the ankle-bones while working nights at the State Prison, as guard. The itching extended with increasing vigor gradually over the other portions of the body, and the skin became hyperemic and scaly, especially on the flexor surface of the forearms; then small nodules appeared under the skin. Oozing was more or less constant, even under the dry skin, when scratched. This condition cov-

ered a period of three years, when the tumors began to form, the first one being noticed about Christmas time of 1897. There were now numerous tumors over the body varying in size from one-half to three inches in diameter. They were well defined, firm, rounded, raised above the surface, but flat and more or less freely movable.

FIG. 1

In nearly all, there was ulceration on the surface with free oozing of a watery offensive adhesive fluid. The tissues were partly necrosed and bled easily when the covering was torn away. The color was of a pinkish purplish hue.

Dr. Biddle states that Dr. Angus McLean and himself, between April 2d and June 11th, 1898, removed various tumors of different

sizes with local anesthesia only, by Schleich's method. It was noticed that when a portion of one of the tumors of the neck was removed for examination, the remaining portion gradually became absorbed. No time was lost from patient's work, and the tissues healed rapidly. Internally thirty drops of Fowler's solution a day was given. One large tumor situated in the center of the back, which showed signs of absorption in June, had almost entirely disappeared in July, and at time of writing, 1899, nothing remained at former site but an increased pigmentation.

The skin of face and neck had cleared up very much, though numerous tumors remained on various parts of his body. His general health continues unimpaired, and since the removal of the tumors, the patient's spirits have improved, though he has always shown a remarkable fortitude throughout his trouble.

I am much in debted to Dr. Warthin for report of a very thorough post mortem and to Dr. Novy for culture and inoculation tests. Only so much of the full report is given here as pertains to the sarcomatous condition and to the structural changes found.

Died Jan. 10, 1901. A.M. Time of autopsy, Jan. 10, 1901, 11 A. M.

*Clinical Diagnosis*: Mycosis fungoides.

*Pathological Diagnosis:* Sarcomatosis of skin; secondaries in tonsils, tongue, right lung cervical, axillary, cubital and inguinal glands (small round cell or lymphosarcoma), melanosis of skin, acute bronchopneumonia, chronic congestion of spleen, liver and kidneys.

Fatty degeneration of liver. Primary edema of Pacinian corpuscles.

*External Examination. Skin.*—Markedly pigmented (about color of Addison's disease). Pigmentation more marked over the abdomen, sides of thorax, flexor surfaces. Skin of the scalp, neck and face presents a diffuse nodular growth covered with dried exudate. Nodules are firm, slightly elastic on pressure. Growth over the neck is more fungoid, there is great distortion of the face, the left eye completely hidden, the growth is larger on the left cheek, so that the face of the cadavers bears little resemblance to that of a human being, though tumors, much shrunken after death.

In addition to these, on the face and head there are other more or less flattened growths on the flexor surfaces; axillary, right forearm, both popliteal spaces and right side of thorax; other smaller nodules are scattered over thorax and extremities. The smaller nodules are covered with epithelium and are firm and elastic. Larger growths are ulcerating, some are umbilicated, others are flat, showing superficial erosions. Growths vary in color,

being yellowish white to deep red, due to superficial vessels or dried blood. Inguinal glands are enlarged. There is a mass the size of a goose egg below Poupart's ligament on the right side. Axillary and cubital glands enlarged. Small umbilicated growth, size of a coffee bean, over the skin of the scrotum.

Throughout, especially over the extremities, are large numbers of small, white flattened scars.

Cross section of the large mass below Poupart's ligament and of masses in all parts of the body show the same appearance: Mottled red and white in color; surface smooth, almost homogeneous. Yields abundant juice on scraping. No stroma visible to naked eye. Growths of the neck and head are of firmer consistency than those over lower part of the body. Between the lesions the skin is dry and scaly, thickened especially about the nipples and about the growths.

*Hair.*—Body hair is markedly atrophic, absent over the scars, very scanty over the genitals, almost absent over the scalp.

*Muscles.*—Small, emaciated and flabby. On section, pale brownish red in color, tear easily. Rigor mortis present throughout, broken with great difficulty.

*Panniculus.*—Almost absent. On section, dry, tough; in color, pale orange.

*Edema.*—Slight over the lower extremities.

*Head.*—Scalp much thickened at many points adherent to periosteum. New growths on forehead extend to periosteum eroding the bone.

*Skull Cap.*—Unusually thin along the anterior part of the longitudinal sinus. Lamina vitrea eroded. Pachionian depressions and meningeal grooves unusually well marked.

*Dura.*—More tense than normal, more than usually adherent to the arachnoid along the course of the longitudinal sinus. Longitudinal sinus negative.

*Inner Meninges.*—Pial veins congested. Pia and arachnoid slightly adherent over the base of the brain. Circle of Willis negative.

*Cerebrum.*—Slight congestion and edema of cortex.

*Ventricles.*—Lateral ventricles slightly distended. Third ventricle negative. Slight cystic change in the choroid plexus. Pineal preserved. Cerebral ganglia. Cerebellum pons medulla negative. Spinal cord not examined.

Position of thoracic organs negative.

*Mediastinum.*—Contains little fat, no enlarged lymph glands.

*Thymus.*—No remains of thymus. Thymus fat in small amount contains a few small lymph glands.

*Pleura.*—Left cavity contains about 60 c.c. turbid yellow fluid. Pleura of right and of left anteriorly is clear, shining; on posterior part of left is dull with scattered fibrin flakes.

*Pericardium.*—Contains a small amount of turbid fluid. Parietal and visceral layers are clear, shining. On anterior wall of left ventricle, just above the apex, are a few fibrin tags (old adhesions). Subpericardial fat in small amount. Shows serious change.

*Heart.*—10½ oz. Normally located. Auricles contain jelly clot, also white antemortem clots. Muscle is deep brownish red in color, is soft, tearing easily. Thickness of right ventricle wall 3 mm.; thickness of left ventricle wall 6 mm.

*Valves.*—Orifices are negative. Thickening of posterior flap of the mitral valve. Beginning arterio sclerosis especially about coronary vessels.

*Left Lung.*—Wt. 1 lb. Length 25 cm., width 20 cm., thickness 7½ c., 7½ cm. Voluminous, entirely covers the heart. Adherent over posterior part of the lower lobe. In color, pale gray pink. Anthracosis moderate. In border are a number of small, flat airless areas.

*Section.*—Lung bleeds freely, parenchyma pale pink, slight hypostasis in the lower lobe. In one of the airless areas at the edge of the lobe is an area of calcification. On pressure there is abundant foamy exudate.

*Right Lung.*—20½ oz. 25x17½x6 cm. Voluminous, not so large as the left. Free throughout. Posterior portion of the lower lobe is hypostatic, almost airless. Upper and middle lobes resemble those of the left side.

*Section.*—Lower lobe is airless in greater part. On pressure yields abundant exudate. Many smaller bronchi contain pus. Color is mottled blue red to grey. Cut surface shows elevated grayish granules, size of pinhead to that of pea.

*Bronchial Glands.*—Moderately pigmented; a few are moderately enlarged. Section shows no change. Thoracic duct negative.

*Abdomen.*

*Abdominal* Cavity.—Contains no fluid. The coils of the intestine more than usually moist. Liver is enlarged, border in the median line being two finger breadths above the umbilicus. Omentum and mesentery poor in fat. Intestines collapsed. Intussusception in small intestine (post mortem).

*Spleen.*—Wt. 8 oz. Entirely covered by the left lobe of the liver. There is an unusual number of deep fissures on the anterior and poste-

rior margins. Capsule is slightly thickened and slightly wrinkled. Through the capsule the color is blue red. Consistency is firm.

*Section.*—Spleen is blue red in color; firm, not rich in blood. Follicles are numerous and enlarged; majority are larger than a pin head. Accessory spleen in pancreatic splenic omentum is almost round, dark blue in color.

*Adrenals.*—Show post mortem change.

*Left Kidney.*—6 oz. 11x6¼x3¾ cm. Anterior surface is irregular in shape; thickness of the kidney is increased over the lower ⅓, thickness is greatest about the middle. Depression along the upper two-thirds is due to the liver border. Fatty capsule is poor in fat. Fibrous capsule strips off easily. Surface of the kidney is blue red in color; smooth. Fetal lobules are unusually well marked; venæ stellatæ are moderately congested; two small retention cysts in the cortex. Cut surface is blue red in color. Consistency firm; cortex ⅝ mm. in thickness. Outlines between the labyrinths and medullary distinct; glomeruli not very distinct. Mucosa of the pelvis is negative.

*Right Kidney.*—4¾ oz. 11x6x2¼ cm. Normal shape. Fatty capsule poor in fat. Fibrous capsule strips off easily. Surface is similar to left. Section is similar to left.

*Bladder.*—Small; contains a small amount of urine. Wall is thickened. Mucosa is congested.

*Duodenum.*—Wall is thinner than normal; duodenum contains bile stained fecal material. Bile passages are open.

*Stomach.*—Pylorus admits finger with some difficulty. Stomach contains blood-stained fluid with some odor. Mucosa covered with yellow green mucous (beginning post mortem change); no enlarged lymph follicles.

*Small Intestine.*—Mucosa is injected; contains no enlarged follicles. Peyer's patches are not enlarged.

*Appendix.*—Narrow, white, slightly constricted about the lower third.

*Large Intestine.*—Contains greenish, soft, unformed fecal material. Solitary follicles in colon slightly enlarged. In cæcum are transverse ulcerations.

*Liver.*—5 lbs. 11 oz. 30 cm.x22½ cm. Greatly enlarged, filling the right and left hypochondria; enlargement of left lobe very marked. Capsule not thickened. Mottled reddish blue and yellow in color. Consistency firm.

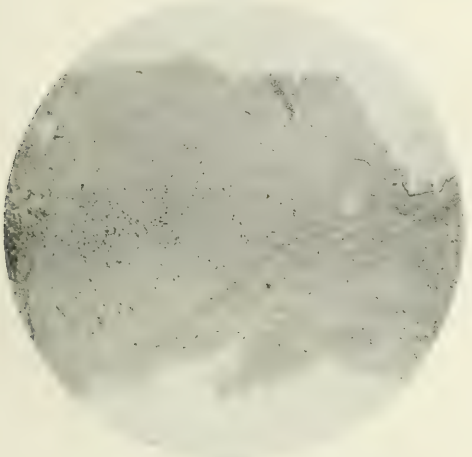
*Section.*—Cut surface is lighter than normal. Consistency increased, especially near the surface. Lobules not very distinct. Central vein slightly filled with blood. Surface is more shining than normal

and shows a few small white points varying in size from pin point to pin head. Gall-bladder distended by golden brown bile. Portal vein negative.

*Pancreas.*—Normal size and shape. Consistency slightly decreased. Section shows no change.

*Mesentery.*—A few enlarged lymph glands back of the pancreas. In the root of the mesentery, near the pancreas are a number of pearl like bodies, rather flattened, size of a millet seed to that of a small pea

FIG. 5



*Low power. Section through depth of tumor.*

—probably Pacinian corpuscles. Mesentery contains a number of slightly enlarged lymph glands, dark red to blue in color. Retroperitoneal glands and glands along ascending vena cava not enlarged, show a dark pigmentation.

*Genital Organs.*—Moderate phymosis. Ulceration of surface of foreskin and glands, extending into urethra. Purulent discharge from urethra. Otherwise negative.

*Microscopic Findings.*

*Skin Lesions.*—Sections made from growths in the skin, taken

from all parts of the body, show the same structure, namely, that of round cell or lymphosarcoma.

The smallest of these growths are confined to the lowest part of the derma, grow by expansion, pushing the papillary layer of the derma and the epidermis upwards. There is but little infiltration about the growths, many of which possess a more or less distinct capsule of connective tissue.

In the majority of cases the smallest growths lie between the

FIG. 6

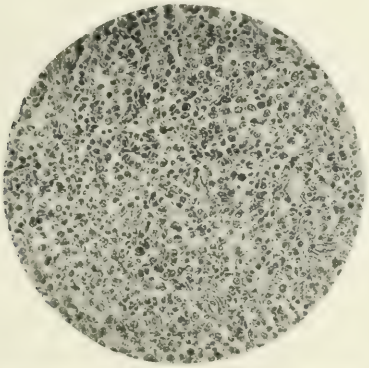
*Low power. Section shows limitation of tumor process below.*

papillary layer and the sweat glands. The structure of the smaller growths is made up of small round cells of nature of lymphocytes among which are larger cells having more abundant protoplasm and less deeply staining nucleus, occasionally containing several nuclei. There is an abundant stroma and throughout the smaller growths are remains of the original connective tissue of the dermis, and occasional retention cysts arising from the sebaceous glands.

On the whole the growths are not richly supplied with blood vessels, many contain numerous small thin-walled vessels lying in direct contact with the cells after the manner of a sarcoma.

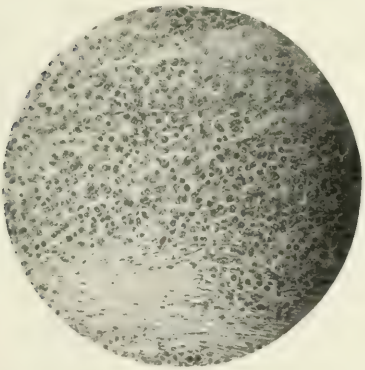
There are very numerous and heavily pigmented chromatophores in the papillary layer just above the growths. Sweat glands in the

FIG. 7.



*Higher power. Cells and intercellular substance.*

FIG. 8.



*Cells, intercellular substance and vessels.*

neighborhood of the smaller growths are hypertrophic, many of them to such an extent that they take on the character of an adenoma, around these there is a more or less inflammatory infiltration; a similar process

is seen in the subcutaneous fat. The larger growths have broken through the epidermis—show a more or less ulcerating surface and extend deeper into the subcutaneous tissue. Occasionally they show areas of simple or liquefaction necrosis, but retrograde change is uncommon; others show an increase of the stroma with atrophy of the round cells with formation of scar tissue replacing the tumor. All stages of this process can be observed up to the completely healed growth, so that throughout the skin of the entire body are found numerous circumscribed areas of scar tissue giving the appearance of progressive development and subsidence of the tumor formation.

In the central portion of the larger growths the majority of the cells have lost their protoplasm, the nucleus remaining either free or surrounded by granular remains of protoplasm. Mitosis is seen in many of these free nuclei. No giant-cells are present, and mast cells are found only in small numbers. Cell-division figures are abundant.

Sections of the skin, taken from all parts, show excessive pigmentation of the chromatophores, circumscribed areas of scar tissue and scattered areas of small-celled infiltration most marked about the sweat glands. Number of mast cells appears to be decreased.

*Tonsils.*—Both tonsils almost completely replaced by growth similar to that in the skin.

*Tongue.*—Small nodules of growth of similar structure on dorsum of tongue showing ulcerated surface.

*Lymph Glands.*—The cervical, axillary, cubital and inguinal lymph glands are replaced by large nodular masses similar in structure to those in the skin. No secondaries could be found in either the bronchial, mediastinal, mesenteric or retroperitoneal glands. The latter show marked congestion; some edema; in some cases a chronic lymphadenitis.

*Hemolymphglands.*—Show hyperplasia of stroma. Excessive pigmentation.

*Thyroid.*—Slight colloid increase.

*Lungs.*—Atrophic emphysema in the lower lobe. Edema and congestion. Extensive bronchopneumonia of the lower lobe and scattered nodules of small-celled infiltration replacing the alveolar structure, showing no necrosis and containing new blood vessels, most probably secondary nodules of the skin tumor. Majority of smaller bronchioles contain purulent exudate and there are numerous fresh and partly organized thrombi found throughout.

*Heart Muscle.*—Brown atrophy. Occasional fibroid areas. Section of the mitral flaps show marked sclerosis with beginning atheromatous change (old endocarditis).

*Spleen.*—Marked hyperplasia, especially of the follicles which are greatly enlarged, much nearer together than normal from the atrophy of the intervening pulp. Blood spaces enlarged; no amyloid found. A small accessory spleen shows similar structure.

*Kidneys.*—Slight atrophy, beginning cloudy swelling, congestion.

*Liver.*—Majority of lobules are large. Fatty degeneration of the cells of the central zone, fatty infiltration of cells in many areas of the peripheral zone. Congestion of central vein and capillaries. Numerous hypertrophic nuclei. No amyloid.

*Adrenals.*—Show post mortem change.

*Pancreas.*—Shows post mortem change.

*Pacinan Corpuscles.*—Show primary edema and cystic change.

*Bacteriological Findings.*

Staining of sections of skin growth for micro organisms by Gram, Weigert's fibrin method, methylene blue, carbol fuchsin, etc., negative.

Cultures made by Dr. Novy at the autopsy were likewise negative (Cultures were made upon blood serum; taken from heart blood, also from a number of growths which were excised whole).

*Points Favoring Sarcoma, and Not Granuloma.*

1. Large numbers of cell-division figures—these are less common in granuloma.
2. Absence of giant-cells which are common in most granulomata.
3. Small numbers of mast-cells and plasma cells, which are usually abundant in or about granulomata and chronic inflammatory processes.
4. Entire absence of micro-organisms, as shown by cultures and staining methods.
5. Nature of metastases.

In a paper read before the Michigan State Medical Society, June, 1895, and appearing in the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, August, 1895, I reported "Two cases of tumors of the skin. One diagnosticated as multiple pigmented sarcoma. Diagnosis of the other reserved," reviewing somewhat fully, though condensed, the accessible literature of the subjects of sarcoma cutis, granuloma and mycosis fungoides. In concluding the report of the first case and quoting the conflicting views of pathologists, and summarizing the opinions, which fairly represented authorities, I stated that "It will be seen that the differential diagnosis of idiopathic multiple pigmented sarcoma of the skin, and mycosis fungoides is neither easily nor certainly determined as yet, by standards heretofore accepted as established."

The second case was seen only two days before paper was read, and the report was necessarily brief. Microscopic examination of tumor on back showed small round celled sarcoma.

There was nothing in family history, either case to indicate any hereditary or acquired specific disease, and there was no evidence that either of the patients gave rise to infection in others.

No micro-organisms were found in either, in sections removed during life, or post mortem, in the second. No post mortem was obtained in the first case.

The history of the first case covered about two and a half years. The second between six and seven years.

The following extract from report shows contrasts in clinical appearance of the two cases:

The salient points of difference in physical conditions, patent at a glance at the photographs, are, the great number and size and nodular character of tumors on extremities in the first case, the elephantiasis-like condition of feet and lower legs, the dry hard darker colored skin, the tenderness and pain, the shorter history and more rapid progress of the first case; and the absence of tumors on the extremities of the second case, though there had been papules, vesicles and small nodules on feet, leaving scales and large macular cicatrices, the absence of pain or much tenderness, but constant pruritus, the more flattened shape of tumors, and the marked prominence of the glandular involvment, the soft reddish color of tumors, and the moist condition or lack of dryness of the skin, and the ability of the patient to be on foot and do so much work with her hands.

The points of resemblance are the facts of both beginning in the hands and feet, the spontaneous improvement at times and retrogression, the rapid growth of tumors and equally rapid resorption, involution, or disintegration, and the absence of anything like typical ulceration. Should the diagnosis of the late case be made on physical conditions and history, it would be called, I think, mycosis. Should it be made on the microscopic findings alone, it must be sarcoma.

I had opportunity to make post mortem in this later case nearly a year later, and found metastatic growths of same structure as external tumors in abdomen, in mesentery, spleen and liver. This fact has not previously been published.

While the study of these dermatoses has been prosecuted with greater vigor than ever within the last few years, and a large number of valuable contributions made to the literature of these forms of disease of the skin, there is still a good deal of diversity of opinion in classification of different cases.

What constitutes a type? and what are "Exceptions that prove the rule?" It is sometimes asked "What's in a name?" "Would not such malignant disease be as repulsive, grow worse and die as certainly, whether called mycosis or granuloma, fungoides, sarcoma, idiopathic or traumatic, pigmented or nonpigmented, sarcomatosis cutis, or generalis—whether of bacillary or other origin? Especially in a disease of such comparative rarity?"

But such questions might be asked about almost every disease of indefinite pathology, and notwithstanding the tendency in dermatology, to complicated nomenclature, it is in the interest, not only of a better understanding of diseases of the skin, but of all Medical Science, to select names expressive of conditions.

"Bright's disease conveyed an indefinite condition before the different forms of nephritis were defined. By the same reasoning mycosis might have been called 'Alibert's disease.'"

If we regard a clinical diagnosis as tentative—a working diagnosis, and not final—the assumption which is to be completed by demonstrating its truth or error, by the aid of microscopic, bacteriologic, chemic and all other means, then we should be less confused by various kinds of diagnoses, but the final diagnosis, when it can be determined, would be more comprehensive and complete.

There is a marked difference between sarcoma as viewed clinically from the surgical standpoint of a few years ago, and making it the head of a group of dermal affections. The beautiful accuracy and reliability of microscopic findings in some cases, and the disappointing results and contradictions with clinical observations and experiences in other cases, is frequently seen. Yet out of all these somewhat unsatisfactory efforts distinct progress is made.

Among the papers bearing on this question of diagnostic classification of clinical features and histo-pathology, presented within the last few years, two may specially be mentioned as covering much of the yet unsettled ground, and as fairly representative of the literature of past three years, and that bear on the case in point:

*First.*—Dr. Jas. Nevins Hyde's address before American Dermatological Association, '98: "A contribution to the study of the so-called premycosic stage of mycosis fungoides."

*Second.*—An address by Dr. J. C. Johnston, before the same association in 1901.

Dr. Hyde, summarizing the different interpretations by different writers of clinical and pathological features of mycosis fungoides, says:

(*a*) "Mycosis fungoides is one of the varieties of sarcoma differing chiefly from the classical type of that disease in the fact of the

occurrence in many cases of dermatoses which precede the formation of tumors." (Practically the position of Kaposi, who regards mycosis fungoides as a clinical type of a single disorder in a group of what he calls sarcoid diseases, with lymphodermia perniciosa cutis, lukemia cutis, and sarcomatosis, as other members of the same group, all exhibiting between them clinical and histological transitions)."

"But opposed to this view are the spontaneous disappearance of many of the tumors, a species of involution rarely, if ever, observed in any other tumor of a malignant type; second, the histological structure of many of the lesions in mycosis fungoides differ widely from the appearances recognized in sarcoma. Third, mycosis fungoides is essentially from the first a cutaneous malady, while sarcoma more often attacks other organs than the skin.

"Furthermore, that the term sarcoma has not the same significance it had even a few years ago, and that some of the affections to which the name was given are now not recognized as sarcomatous.

(*b*). "That mycosis fungoides belongs to the family of infectious granulomata—histologically a more tenable view, but thus far no pathological organism has been discovered, and no history of infection or contagion reported."

(*c*). "A view promulgated in France which discovers in its phenomena a primary lesion at the site of infection, and the evolution of a disorder in relatively definite stages analogous to those of syphilis."

Hyde concludes a preliminary report based on a review of over forty-five cases in which various dermatoses existed and were studied for months or years before the tumor formation began, and upon incompleted bacteriological and histological investigation of two cases. The work done will not justify definite conclusions regarding the nature of the disease, but we think it furnishes some evidence in favor of the belief that there are early dermatoses, though differing considerably in clinical type, have many characteristics in common, and are the varied expressions of a definite morbid process, that the disease is quite distinct from sarcoma, and that it differs markedly from the recognized infectious granuloma in that its manifestations are confined to the skin, but one case having been reported in which internal organs are involved.

Dr. J. C. Johnston, in JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, July, 1901, in an able paper under title, "Sarcoma and the Sarcoid Growths of the Skin"—an endeavor to bring about if possible an agreement in the consideration of the subject of sarcoma in dermatological and general pathological literature. In a "histogenetic" classification he divides sarcomatous neoplasms into

three groups: (1) Fibroblastic (true) sarcoma; (2) the lymphoid cell class, and (3) sarcoid growths. There is no clinical sign by which to distinguish the cellular varieties of sarcoma.

"Sarcoma is ordinarily divided according to the type of its cells into spindle, round and myeloid, or giant-celled forms. Giant cells may occur in either of the first two types, rarely appear as constituting even the major portion of a tumor, and have no special significance except that when abundant their number points to bony origin. Spindle and round cells are capable of direct transformation, one into the other, so that in reality there is one sarcoma which originates from the fibroblasts, either of the adventitia of vessels or of ordinary connective tissue, and that at the outset it seems probable that all sarcoma cells are spindles.

"In this scheme the second subdivision, the lymphoid-celled group, includes leukemia, pseudo-leukemia, and malignant lymphoma (the latter also called lymphosarcoma). All sorts of anomalous cases have been noted, particularly by Kaposi, in which it was impossible to determine the character of the disorder, except that its cells were lymphoid. And that these indeterminate cases which, according to him, may shade into leukemia, pseudo-leukemia or mycosis fungoides. These patients usually die from marasmus, preceded by development of lymphatic abscesses, fungoid tumors, adenopathy, or true leukemia.

"*The So-called Sarcoid Growths.*—The members of this growth have been in dispute since Alibert's classical description of mycosis, or as it is now called, granuloma fungoides—(though he states that not all investigators are agreed that the disease is a granuloma). The class had close relationship on one hand with sarcoma, and on the other with granuloma, consequently with productive inflammation. No infective agent has been demonstrated by culture or inoculation in the causation of any of the group, as yet. The diseases considered under this group are (1) granuloma fungoides, (2) multiple idiopathic pigmented sarcoma, (3) sarcomatosis cutis, and (4) multiple benign sarcoid. Metastasis in internal organs has been reported once in the first, and in one doubtful instance in the second."

He mentions the reports of Malherbe and Monnier of a case in which there were metastasis in the axillary inguinal, bronchial and mesenteric nodes in the breast, lungs, pleura, kidneys, pancreas, uterus, ovaries and heart. But he thinks this case not without suspicion, as in addition to the extraordinary dissemination the authors described "marked leucocytosis," and class it with lymphadenoma.

The condition called sarcomatosis cutis is variously described. Kaposi gives the name to his third variety of sarcoma cutis, the others

being mycosis fungoides and lymphoderma. Fendt asserts that its is a granuloma.

Though I have drawn so freely from these valuable papers it is impossible to abstract either of them and do justice to their merits. A few practical points may be made of possible value to those who render "first aid" to such cases.

First, every persistent case of general pruritus with or without skin lesions should be suspected and if possible kept under observation. Also all lesions in extremities of an indefinite or uncertain character. Unfortunately, so far, treatment offers but little encouragement in late stages.

Arsenic has given best results, and some recoveries from mycosis are reported. Some spontaneous, and others attributed to treatment. Most cases have ended fatally. If treatment is to be effective in any of those conditions, by whatsoever name called, it must be in early stages, before the disease is generalized, whether by systemic infection or metastases. In the absence of more definite knowledge of etiology or pathology, remembering its frequent apparent local origin, it is not an unreasonable speculation, that cases of apparent erythema, eczema, or of the many forms of dermatitis, and successfully treated as such, may have warded off, or aborted a mycosis, or sarcoma cutis just as epitheliomata of seborrhetic origin by degenerate processes, have been arrested by timely treatment.

# Obituary.

The Reaper has been busy in the old school in Vienna since the first of March. Besides Kaposi, whose death was noticed in the June number, ADOLPH JARISCH who, it was said, was his logical successor in the chair of Dermatology, and HANS V. HEBRA, who had long since won a place in the distinguished coterie, have passed away. This sad decimation would seem to mark the end of an era, that of the pioneers and of the domination of master minds. It is as true of dermatology as of other lines that this is an age of little men. Certainly it is positive that no man does or can hold the place Kaposi has left vacant, and which he inherited from the elder Hebra. Directly or indirectly, they two taught and influenced every man at work in the specialty to-day, and while Kaposi after Hebra's death became a Bourbon of the Bourbons, it is easily forgotten in view of his noble legacy which is ours as it is the Austrians'. One hundred and ten contributions to dermatology, including six larger works and monographs, extending over a period from 1866 to 1900, represents his life work. If he found it convenient to prefix "noch einmal" to his last article on lichen, it merely served to remind the reader that he of all men had the best right to an opinion since Hebra and he had first set it in its proper place. It is rumored that Riehl is called to carry on the traditions of the school in Kaposi's stead.

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The following is a tribute of the New York Dermatological Society:

The New York Dermatological Society at a meeting held April 22, 1902. adopted the following resolutions:

*Whereas*, Professor Dr. Moritz Kaposi, an honorary member of our society has been removed from us by death; be it

*Resolved*, That on the death of Professor Kaposi, the Society has lost one of its most eminent members; one whose high professional attainments, scientific achievements and work as a leader have made his name famous through the whole medical world.

*Resolved*, That our deepest sympathy be extended to his family in their great sorrow, and that a copy of these resolutions be sent to the family and medical journals for publication.

S. LUSTGARTEN, M.D.,
Committee.

# Society Transactions.

## NEW YORK DERMATOLOGICAL SOCIETY.

305TH REGULAR MEETING, APRIL 22, 1902

JAMES M. WINFIELD, M.D., *President.*

**A Case of Warty Tuberculosis of the Foot Treated by the X-Ray.**—Presented by DR. J. M. WINFIELD.

The patient was a young lad, who had come to him in December with a warty growth on the dorsum of the foot that had been present for about a year previously. The case had received six applications of the X-ray, the treatments being given once a week for six minutes at a time.

DR. A. R. ROBINSON said that the diagnosis was probably tuberculosis verrucosa cutis. With a history of one year's duration and of a gradual spreading from the periphery, this would seem to be the most reasonable diagnosis. The case also suggested blastomycetic dermatitis. About one year ago he had shown to the society a case, which most of the members thought to be one of blastomycetic dermatitis, but it had turned out to be a dermatitis with papillary formation dependent entirely upon pus organisms. For this reason he would not be willing to make a positive diagnosis in the case under discussion without having made a proper microscopical examination.

DR. L. DUNCAN BULKLEY coincided with the views expressed by Dr. Robinson. He believed that the systematic use of the microscope would lead to the discovery of more cases of blastomycetic dermatitis in this city.

DR. CHARLES W. ALLEN accepted the diagnosis, and agreed as to the treatment to be employed. If the X-rays did not work with sufficient rapidity, a caustic paste could also be used. There seemed to him evidence already of a decided effect having been produced.

DR. P. A. MORROW accepted the diagnosis of tuberculosis verrucosa cutis. He thought the case could be cured more rapidly and with greater ease simply by curettage followed by the application of the Paquelin cautery. However, it was well to experiment with the X-rays on as wide a range of cases as possible. As to the combined use of caustic paste and the X-rays, he would say that he had been treating three cases of lupus with the X-rays for some time. One of these cases had also been treated with the galvanocautery, using a small point to destroy the tubercles. The patient had been subjected on two occasions to the treatment almost immediately after having twenty or thirty punctures, and the action of the X-rays under these circumstances was certainly much more pronounced than when applied to the unbroken skin. He thought it might be well to adopt this combined method.

DR. J. A. FORDYCE thought the case could be treated by curetting the patches and then applying the Paquelin cautery or pyrogallic acid.

DR. C. C. DAVIS thought it was a waste of time to use the X-ray on this class

of cases. The X-ray only dried up the patch; hence it was much better to resort to the use of the curette and the cautery.

DR. WINFIELD said that he was simply using the X-ray in this case experimentally. The boy was feeble-minded and his mother was very averse to all surgical measures. He was aware that it could be more easily removed by the curette. He had made a microscopical examination of the tissue and had found giant cells and the usual picture of tuberculosis.

**A Case for Diagnosis.**—Presented by DR. SHERWELL.

Mr. C. M., aet. 45, perfect family history, and never been ill himself beyond the usual diseases of childhood.

The present lesions had first appeared about 2 years since, and seemed from description to be eczematous, but not much serous exudation, confined to lower limbs, and chief manifestations not much above knee, began to take on the fungoid, warty appearance, which they now present, about a year since, with considerable edema, reaching nearly to the inguinal fold, and most marked in left leg. Deep indurated patches can be felt, seemingly of lymphatic implication or stasis at least, in lower thigh.

From its general appearance, it had seemed to him that there was a probability of its being mycosis fungoides, though not classical in form or distribution of lesions.

DR. MORROW did not think this represented a phase of mycosis fungoides, as it did not seem to him to present the characteristic features of that disease. Moreover, he had never seen a case of mycosis fungoides in which the disease was confined to the lower extremities; it almost invariably affects the trunk, face and scalp. The trunk was primarily and most characteristically the seat of the lesions of this disease. Regarding the suggestion that the case might be one of hypertrophic lichen planus, he could not accept this view. In many cases of papular eczema lesions were observed which might be mistaken for the papules of lichen planus. He could not say what was the exact nature of the case, though it might be one of eczema exhibiting unusual features because of some peculiar source of irritation.

DR. FORDYCE thought the case was probably not mycosis fungoides, and he was more inclined to think it was hypertrophic lichen planus.

DR. DADE said he could not agree with Dr. Morrow on the points of diagnosis of mycosis fungoides. Dr. Fox had kept under observation for a long time a case in which the disease was confined to the lower extremities.

DR. H. G. KLOTZ thought the case presented many of the features of hypertrophic lichen planus, but the original conditions were apparently complicated by a dermatitis, due to some irritant.

DR. ALLEN regarded the case as a lichen planus of the hypertrophic form on the extremities, with a complicating dermatitis from external irritants, such as scratching. He had no doubt that under appropriate treatment for lichen planus, including curettage of the large lesions on the extremities, the man would recover. He would give internally alkalies, arsenic and podophyllin.

DR. BULKLEY said that he had seen such conditions on the leg repeatedly in old cases of eczema. He was sure the ugly masses on the legs would disappear entirely under the use of rubber bandages. He would certainly exclude mycosis fungoides.

DR. A. R. ROBINSON felt very much as did Dr. Bulkley regarding the case. He saw no evidence of mycosis fungoides. The lesions on the elbow could not be diagnosticated from the lesions of lichen planus, but with such extensive

lesions if the case were one of lichen planus there ought to be other lesions characteristic of that disease. He did not think the condition presented by this patient was so very rare in patients having such a poor circulation, with perhaps also an excess of uric acid in the blood. He should prefer to call this an eczematous dermatitis dependent upon some noxious agent from within rather than from without.

DR. BRONSON said that the case was certainly not a typical one of eczema. Though every now and then warty outgrowths were encountered in eczema, it was usually in much more chronic conditions than appeared here. These warts project from a surface that is only slightly infiltrated. He would exclude mycosis fungoides; the inflammation was too diffuse and the tumors too brawny and not vascular enough. It was possible that there was a substratum of lichen planus, but he understood that the itching was not very marked, and he failed to see a distinct lichen planus papule. The papules looking at first glance like lichen planus did not appear on close examination to be true papules at all. A similar condition was frequently seen in a retrocedent eczema. The element of adherent scales, almost always present in lichen planus, was absent here. Again, in the distribution of the eruption there was not the arbitrary character of the grouping of lichen planus.

DR. GEORGE THOMAS JACKSON said that he saw no evidence of mycosis fungoides, as it was too diffused, and not patchy enough, it was entirely too inflammatory to be lichen planus. He would look upon it as a case of papillary eczema with warty outgrowths.

DR. SHERWELL said he was much obliged for the extended discussion and the careful examination of the case. He had taken into consideration the fact that it was never on the head, face or body, and yet he had never seen, in a man of that age and robustness, such an exaggerated nodular condition with so much swelling, and relatively so little itching. This man did, however, have a good deal of stinging pain. He had received practically no medicine; hence drug eruptions could be excluded. Dr. Sherwell said that in his experience he had never met with such large, warty excrescences in eczema.

**A Case of Partial Hemiatrophy of the Fifth Nerve.**—Presented by DR. E. B. BRONSON.

The patient, Miss McM——, eighteen years of age, presented a supraorbital atrophy of the skin. She stated that the affection had been first noticed about five years ago, following an operation by an orthopedic surgeon on the tendo Achillis. At this time her nervous system was generally in an irritable condition. The lesion on the forehead began just below the border of the hair, slightly to the left of the median line, and gradually extended downward in the direction of the inner angle of the left eyebrow. It had been at its worst a year or two ago, so far as the depth of the depressions and whiteness of the skin were concerned. Some time after the first atrophic lesion was noticed, it was remarked that a similar depression, less in degree, had formed to the left of the other, becoming near the hair, and inch and a half or two inches from the median line and passing down obliquely towards the inner angle of the eye. At present, the latter depression was perceptible, but not very distinct, while the alteration of contour from the inner one was decidedly marked. There appeared to be no sclerosis in the affected tissue and no cicatrix. At the root of the nose, and near to the left of the median line was a faint scar, which had followed an injury received by a horse when she was a small child.

DR. ROBINSON said he was doubtful about such a fan-shaped atrophy being due to an injury down near the eye.

DR. BULKLEY agreed concerning the impropriety of calling such cases morphea.

DR. BRONSON said that he had not examined the case carefully with the esthesiometer, yet there was apparently no loss of sensibility. The case seemed to be interesting because of the injury in childhood. It seemed to him quite possible that that injury had done some harm to the supraorbital foramen, and that only under the influence of some subsequent trouble had it given rise to a neuritis. He saw no reason why it should not affect the periphery first—indeed, he would think this would be the more likely course.

**A Case of Obstinate Psoriasis.**—Presented by DR. G. H. FOX.

Dr. Fox said he had been surprised to find a case of psoriasis in which a twenty-per cent. ointment of chrysarobin had almost no effect in producing a dermatitis. Various brands of chrysarobin had been tried with like result.

DR. BRONSON said that it had been his experience with cases of psoriasis that did not yield readily to chrysarobin that they would do so when this local treatment was combined with the internal use of arsenic. He recalled a remark of Jonathan Hutchinson that those cases of psoriasis which were not typical in their location always prove rebellious to treatment.

DR. SHERWELL said that he almost always combined the internal with the local treatment in cases of psoriasis. It was certainly most extraordinary that the chrysarobin had not produced the usual effect of staining, etc.

DR. ALLEN said that he had recently shown a case of psoriasis to the society, and had been criticised for the use of the X-rays in that case because, it was said, psoriasis could be so readily controlled by chrysarobin. The case that he had presented had been vigorously treated with chrysarobin and other similar remedies without much benefit, and hence he had used the X-rays. He had continued the treatment with X-rays, and had exhibited this patient last evening before the New York County Medical Association. As he had applied the X-rays to one side at a time, the effect was very striking. He would advise Dr. Fox to try the X-rays in his case.

DR. ROBINSON said he never used chrysarobin except in cases of psoriasis having a few lesions of long standing, and where there was no tendency to new lesions—in other words, he did not regard chrysarobin as a preventive of new lesions. His treatment consisted in an effort to secure a proper degree of alkalinity of the system, and then in giving arsenic and properly regulating the diet. He had always been perfectly satisfied with this line treatment.

DR. KLOTZ said that he had not found chrysarobin uniformly effective in psoriasis. Sometimes even infiltrated patches of psoriasis yield much better to some mild remedy, for instance, a two per cent. salicylic acid ointment.

DR. BULKLEY said that the intense redness in this case would indicate to him the necessity for thoroughly alkalinizing the system. He would never think of giving arsenic to a case presenting as much congestion as exhibited at present by this patient. With regard to the application of chrysarobin he had been using chrysarobin in equal parts of oleum rusci and alcohol painted on the part, and had found it more effective than the chrysarobin ointment alone.

DR. DADE said that in cases of psoriasis in the progressive stage very little could be accomplished by any treatment, while when the disease showed a tendency to retrogression almost anything would benefit it.

Dr. Morrow said that he had had under observation a case which showed that the susceptibility to chrysarobin might be marked for a long period, and be finally lost. The patient referred to had been sent to him by Dr. Keyes eight or ten years ago. He had whitened his skin probably half a dozen times in the course of a few years. The reaction of chrysarobin had been prompt, but in another outbreak, occurring a year and a half ago, this patient had used the remedies formerly prescribed without benefit. Six months ago he had returned to Dr. Morrow, and several different preparations of chrysarobin had been tried, without effect upon certain patches on the back and knees. There was a band on the forehead and another about the ears, and these yielded promptly to pyrogallol or chrysarobin, while the patches on the back and knees were absolutely unaffected. He had used frequently one drachm of salicylic acid and two drachms of chrysarobin to the ounce without producing any dermatitis. Recently he had obtained better results from Emplastrum Hydrargyri. This patient had been thoroughly alkalinized some years ago, and still later had taken arsenic up to the physiological effect.

There was much that was peculiar about the action of chrysarobin. In one case the white patches, following the use of the chrysarobin, were very marked. A year later the chrysarobin was applied to a second patch of psoriasis, and then the white patches that had been left after the first tretment with chrysarobin, appeared, as proved by photographs. These cases in which chrysarobin produced little or no effect were certainly very rare, for, he used this remedy as a routine measure, and very seldom observed this peculiar insusceptibility to it.

DR. FOX said that this patient had had very many methods of treatment, including mixed treatment and a thorough course of the alkalies. Arsenic had been given in full doses, but had exerted no influence upon the course of the disease. The hands had improved considerably during the past few months, for at one time they could not be opened on account of the keratosis. The use of rubber gloves had apparently done good. He had used the chrysarobin in both weak and strong ointment, and also as a varnish combined with ichthyol. Ammoniated mercury had also been used locally. As to the permanent change in the skin left after chrysarobin had whitened it, he would say that he had observed a case in which as the edges of the scaly patches began to whiten, a number of other white disks appeared in other places where the skin was perfectly healthy. So far as he could judge, these spots were exactly where the lesions had been made to disappear a year before by the use of chrysarobin.

DR. ROBINSON said that he had made a good many sections of the skin of these patches, and had found that the lower row of cells ordinarily containing pigment no longer contained pigment.

**A Case of Disease of the Nails.**—Presented by DR. P. A. MORROW.

The patient was a gentleman who had never been troubled with any eruption of the body. About one year ago he noticed a disease of the finger nails. It had involved all of the nails on both hands, with the exception of the index fingers. The nails had lost their translucency and seemed to be worm-eaten or pitted, as if the hard portion of the nail had been picked out. The nails of the toes were affected in a similar manner.

DR. FOX regarded this as a beginning eczema of the nails. He believed it often affected the nails alone before appearing elsewhere, particularly in arthritic subjects. It had been claimed by some that most diseases of the nails were parasitic, but the supposition had not been substantiated by the presentation of anything to the society.

DR. FOX said he did not believe that in cases in which all the nails of the hands and feet were affected almost simultaneously that the affection was parasitic in nature, nor did he think such a case could be diagnosed as eczema. He would rather put it down as due to malnutrition of unknown origin.

DR. GEORGE T. ELLIOT mentioned the case of an unmarried woman in his practise who, at the first indication of the climacteric, developed a fissuring, discoloration and breaking of the nails. At the same time a very extensive alopecia areata became evident. It would seem difficult to attribute such a case to parasitic causation.

DR. SHERWELL said he did not think this condition of the nails was mycotic or eczematous. The true explanation, in his opinion, was to be found in an underlying gouty condition. Probably the affection of the nail began with a minute gouty deposit in the capillaries about the nails, thus disturbing their nutrition. He would look for better results from improving the constitutional condition, and antilithic remedies.

DR. BRONSON said that while the condition was commonly called eczema of the nails this seemed to him a decided misnomer. It was not an inflammation apparently; simply an atrophy or imperfect development of the nails of unknown origin. He had presented to the society a more aggravated case of this kind. The nails were blackened and some of them had been shed entirely. This person was now entirely well, having recovered under the use of arsenic.

DR. JACKSON said that the trouble seemed to be dependent upon disease of the matrix of the nail, and the gouty theory formed a good working basis.

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# Selections.

## GENITO-URINARY DISEASES.

**A Clinical Lecture on Tuberculosis of the Bladder.**—By P. J. FREYER, M.A., M.D., M.Ch. (*Edinburgh Med. Journal*, January, 1902, p. 38.)

Tuberculosis of the bladder is now recognized as a much more common disease than was imagined some years ago. The extended use of the cystoscope and bacteriological research as aids to diagnosis, have brought about the recognition of the comparative frequency of this condition. Primary tuberculosis of the bladder is very rare, and may begin in any part of the bladder, but it is most frequently seen by the cystoscope in its earliest stages on the posterior aspect of the viscus, behind the inter-ureteral bar.

In a secondary invasion of the bladder from without, the disease follows the same laws of invasion as to locality as in primary tuberculosis of that viscus, but in the majority of cases, bladder tuberculosis occurs secondarily to a pre-existing focus in the kidney or genital apparatus. In the descending variety (from the kidney) the bladder is first invaded around the orifice of the corresponding ureter; while in the ascending variety (from the genital organs) the disease first shows itself at he neck of the bladder in the trigone. In the adult male these two sources of invasion are about equally common; but in male children the descending form is most frequent. The bladder in the female is much less commonly affected than in the male.

Infection of the bladder takes place (1) through the blood, (2) by the lymphatics, (3) by extension through continuity or surface, along the mucous membrane from the kidney or genital organs (the most common form), (4) by direct ulceration from the prostate into the bladder, and (5) by infection from the kid

ney, through the urine. The kidney may be diseased for years without infection of the bladder following. The mucous membrane of the bladder appears to possess considerable powers of resistance against the tubercle bacilli. Congestion, inflammation, or abrasion of the mucous membrane, is probably essential in order to render it amenable to attack.

Dissemination of the tubercle takes place rapidly if the bladder becomes infected by pus microbes, induced by the introduction of septic instruments, or otherwise. The tubercular ulcers, though shallow, as a rule, sometimes eat their way through the whole thickness of the bladder wall, or into the perivesical tissues, causing fistulæ or urinary abscesses, and making their way to the surface in the groins or perineum. This is a rare occurrence. In advanced stages the walls are considerably thickened, and the bladder cavity contracted, and perhaps pouched.

The differential diagnosis between stone and tuberculosis can only be made by [illegible]. The symptoms are about the same. Hematuria is not infrequently the earliest symptom, and it is usually unaccompanied with pain. The hemorrhage may be profuse even with but slight ulceration. It is at first intermittent, lasting from two to three days, the next attack not occurring for weeks or months. These attacks become more and more frequent, and eventually blood is constantly found in the urine. The hematuria is profuse when the ulceration is situated near the neck of the bladder. Here the patient complains of pain and increased frequency of micturition are invariably present. The latter symptom is rarely so profuse as when there is a growth in the bladder. The pain and frequency of micturition are characteristically not influenced by exercise. The pain is not confined to the penis, behind the glands, as in stone. It extends along the whole canal, and is of a burning or scalding character. With extensive ulceration, pain is constant in the hypogastric region, and is most enhanced when the bladder is emptied. General cystitis aggravates all the symptoms.

In females, especially in females, incontinence of urine is not an uncommon symptom. In addition, pain in the neck of the bladder is marked. Loss of weight is an early symptom.

General hygiene and medical treatment is of the greatest importance. The [illegible] general principles as if the lung or other organ were involved. Urotropin, freely diluted with water, is the most efficient drug for the [illegible]. Salol has been [illegible].

In tubercular cystitis [illegible] not only painful, but actually injurious. Potassium iodide is the most effective remedy to be employed. Solutions of 1 in 10,000 gradually increased to 1 in 2,000 are recommended. One and one-half [illegible]. Potassium citrate, in 2 drachm [illegible].

Operative treatment is rarely indicated, and should be resorted to only when the general treatment fails, because the problematic benefits of the treatment are [illegible] infection by instrumentation.

[illegible] and [illegible].

The best procedure is [illegible] by the suprapubic route. In a minority of cases, curetting the ulcers through this opening, with a sharp spoon [illegible] has been [illegible] of the disease.

A. L. W.

# Therapeutic Reports

## THE PREVENTION OF OPHTHALMIA NEONATORUM.

In an article on the prevention of ophthalmia neonatorum Dr. Lucien Howe, of Buffalo (*Philadelphia Medical Journal*, January 18, 1902), whose name is so prominently identified with this subject, urges the enactment of laws which will make it compulsory upon the practitioner to adopt some form of prophylaxis against this disease, which is responsible for so many cases of blindness. He cites statistics by Kostling, showing that in 17,000 births where no prophylactic treatment had been employed some trace of ophthalmia developed in over nine per cent., whereas in 24,000 children treated by the Crede method the number who developed the disease was only one-half of one per cent. The Crede method, however, has the disadvantage of always producing some pain and usually more or less conjunctivitis, while in a few instances it has given rise to corneal ulceration. According to the statistics of Potrowski, in 1,030 children treated with a strong solution of boric acid and a ten-per-cent. solution of protargol not a single case of ophthalmia occurred, while slight catarrhal conjunctivitis was observed in only 1.2 per cent. Aside from the numerous favorable reports on the value of protargol as a prophylactic against this affection by European authors, the drug is preferred for this purpose by many ophthalmologists in this country, including Drs. Alt, Peck, Cheney, Fox, Hotz, Zimmermann, Converse and Todd. In commenting upon Dr. Howe's paper the *Philadelphia Medical Journal* remarks editorially: "If we cannot reach the fons et origo of ophthalmia neonatorum, we can at least save the offspring from a life of darkness, and protect the community from a source of burden and expense. That this can to an enormous extent be accomplished by prophylactic instillation need hardly be repeated, and its negligence constitutes a sin of omission that deserves commensurate punishment. The enactment of such a law is feasible, its interpretation obvious, and its enforcement not difficult, provided the accoucheur receives the intelligent support of an intelligently instructed community."

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## IODIPIN AND ITS USES.

Dr. Blanck[1] writes on iodipin, basing his remarks on experiments personally conducted and on the reports of others. Taken internally, the drug passes the stomach unaltered and is partly split up in the intestines. The greater part is,

[1] Therap. Woche, Dec. 4, 1901.

however, absorbed and transported by the blood to the tissues, which it saturates. Thus depots of iodine-fat are established in different parts of the body, whence the iodine is [illegible] gradual and prolonged action of the drug [illegible]. The [illegible] mildness of untoward effects, which is [illegible].

[illegible]

[illegible] has been reported [illegible] the [illegible] the [illegible] this period, a motor insufficiency [illegible]

[illegible]

[illegible] iodipin medication, and usually [illegible] asthma, emphysema, scrofulosis, arteri[illegible]

Dr. Kircher reports a case of actino[illegible] treated recently. The disease affected the patient's cheek and [illegible]. After puncturing the characteristic abscess and [illegible] the [illegible] the [illegible] two days to subside. On the fourth [illegible] a dram of iodipin was given. Later on injections were [illegible] five days, altogether 1 oz. of the remedy being administered. Complete cure was obtained in four weeks. The same treatment had in two previous similar cases effected an equally gratifying cure.

Dr. [illegible] has experimented with the remedy in all ocular affections indicating the administration of iodides, including some cases of ophthalmic migraine. Incidentally he has been able to note the beneficial effect of the remedy in other diseases, such as asthma, chronic inflammatory affections of the female pelvic organs, etc.

Several hundred patients received treatment in the course of about two years. Many of them owe their improvement or recovery, [illegible] having been found ineffectual. For weeks and even for months iodipin was tolerated [illegible] one exception, an elderly patient of sixty-six years.

Among the disorders found amenable to the [illegible] remedy the author mentions scrofulous inflammation of the eye, which yielded to the internal exhibition of iodipin [illegible].

Several cases of [illegible] iritis due to constitutional syphilis were [illegible] by the [illegible]. The

same may be said of chronic inflammatory conditions of the eyeball without diffuse opacities of the vitreous body. These latter showed themselves very obstinate to treatment, while solitary opacities due to progressive myopia and other causes yielded readily. An old case of abducens-paresis also improved under iodipin medication.

Generally speaking, the author recommends the remedy chiefly in chronic affections, requiring a prolonged action of iodine. In acute cases calling for a rapid action of iodine, iodipin may be given in combination with the alkaline iodides.

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## ANÆMIA AND ITS TREATMENT

By Deering J. Roberts, M.D., Nashville, Tenn.

Abstract from the *Southern Practitioner*.

Case I.—Gastric Ulcer, Acute. Female, æt. 53 years, school teacher, previous health good for years, was suddenly attacked with profuse gastric hemorrhage, which persisted at frequent intervals for three consecutive days. The loss of blood was alarming, and the amount and her general appearance justified the most unfavorable prognosis on the part of my associates in the case, who gave up the case as hopeless. The hemorrhage subsiding, alimentation by the rectum solely and Pepto-Mangan by the same channel for two entire weeks was resorted to, noting per oris except the least possible amount of ice water or crushed ice to relieve thirst; then a cautious return to gastric alimentation and Pepto-Mangan by the stomach for four weeks more, when she returned to her duties. No other medicines were used other than an occasional hypodermic of morphia during the first week to allay restlessness and procure sleep.

Case IV. Bright's Disease. Male, æt. 58 years. Theatrical machinist; a moderate and sometimes a hard drinker. Diagnosis in February last, chronic albuminuria of several years' standing. Amount of albumen in three samples of urine examined, 37, 42, and 33 per cent., together with epithelial casts. Marked anæmia and great debility. Was compelled to give up his job before the close of the season. I placed him under treatment, but, finding I was making no headway, I advised him to go to Red Boiling Springs. This his financial condition did not permit. Left off all other medicines, gave him advice as to diet, and ordered Pepto-Mangan (Gude), one bottle. This he repeated from time to time during the summer, and, although not cured, he is much improved. Says that he feels better than he has done for years, is strong, or seems so, and resumed his occupation, and has been steadily employed since the opening of the theatrical season this fall.

Case V. Chlorosis and Amenorrhœa with Dysmenorrhœa. School girl, æt. 16 years. Menstruation only occurring at irregular intervals of two or three months since entering her fourteenth year. Pale, anæmic, irregular appetite, at times complete anorexia; when menstruation did occur it was very scanty, sometimes almost devoid of color and very painful; headaches, backache, constipation, with nearly all the other phenomena seen in such cases, showing up from time to time. Had been unable to attend school the last two years, though very anxious to do so. Having tried many other measures but with little satisfactory or permanent improvement, I was much gratified at the results from Pepto-Man-

gan (Gude), which I commenced in July last. Her last three periods at intervals of twenty-eight days have been passed with the greatest satisfaction, each one increasing in volume, unattended with pain, and she seems now, from her active and vigorous condition, her appetite, her ruddy complexion, her gradual gain in weight from 70 to 93 pounds, to be well on the way to recovery, if not entirely relieved, and expects to again commence her schooling with the incoming year.

(N. B.—The Breitenbach Co. have recently won, on appeal, case in the Massachusetts Superior Court, protecting their rights in this preparation.)

## PINUS CANADENSIS IN SCABIES.

By Orrin [illegible], M.D., [illegible], Kans.

I used S. H. Kennedy's Extract of Pinus Canadensis in the case of two brothers. Each had the same disease, scabies. Deep-seated pustules between the fingers, extending to the wrists. Intolerable itching and excessive heat. One case came to me at once and I used soap and water and then applied ointment. R Ung. Sulph. 3ss, Pinus Canadensis 3ss. The case was entirely well in three weeks' time and not a sore or any bad effect whatever. He said I was a good physician. He showed his brother who had been under the treatment of another doctor, but was not improving. He was even getting worse under his treatment. The Doctor told him it was impossible for him to be cured under another treatment at once, and might be years. (I should like to see the brother's case; they said it was a wicked looking case.) I began and gave the second brother the same treatment which I had given the first, with the result of a cure in about three weeks. But the case is badly scarred, deep pitted, and [illegible] are extremely pleased to get rid of the dreadful disease. Still I [illegible] and feel I owe the cure to the [illegible] Pinus Canadensis in No. 3.

## NEW TREATMENT OF LEUCORRHEA AND OF GONORRHEAL VAGINITIS.

By Dr. Ph. Chapelle, Paris.

Yeast in the treatment of chronic leucorrhea and [illegible] has [illegible] with considerable success. Dr. Landau of Berlin was the first to apply it locally by injection for [illegible] vaginal secretions, and found small quantities produced a rapid and considerable effect of the discharge [illegible] few weeks.

Many [illegible] used it in the same manner in gonorrheal discharges from the vagina, and found yeast most effective in suppressing inflammation of the mucous membranes, which regained their normal color rapidly. In the gonorrhea of men, however, it was not uniformly successful. In leucorrhea and [illegible] vaginitis, there seems a substitution of a morbid fermentation, for a non-deleterious yeast fermentation, for the yeast cells [illegible] appear to devour the morbid germs, which set up inflammatory conditions.

Backer, who has made a study of the various ferments, is of the opinion that the natural toxines, however altered, may in the treatment of disease be replaced with advantage by ferments in the living state. He considers good health to be one of normal fermentation, and bad health one of morbid fermentation.

Hence, pure ferments like yeast attract pathogenic germs, allow themselves to be penetrated by them and envelop, destroy them by a true pinocytosis. D'Arsonval and Charrin have also made a series of interesting notes on the reciprocal [illegible] of microbes on vegetable cells [illegible] and I would account that in the case of yeast, in its struggle with pathogenic germs, it extends its [illegible] to respect, aiding it materially by reason of its phagocytic properties.

We can therefore [illegible] why the treatment of leucorrhea and other vaginal discharges with yeast, is based on reasonable principles, and it merits therefore to find

in obstinate cases, which do not yield to tonics and the usual local treatment.

The application of yeast in this connection is not convenient owing to its keeping badly, its offensive smell and the difficulty of obtaining fresh supplies, as well as its inconvenient frothy nature, which makes it difficult to be retained when injected. This, however, can be overcome by using the pure desiccated form, known as Cerevisine, which may be exhibited in the form of a pessary of cocoa butter filled with Cerevisine, and placed in position on going to bed, or a paste made up with glycerine of starch, and retained with a tampon of absorbent cotton, or cream applied by dipping absorbent cotton in a thin paste of Cerevisine and water. The quantity for application is not important, as it is perfectly harmless, but from one to two teaspoonfuls can usually be introduced and retained in the vagina during the night, which will give more cleanly and comfortable results than injections of brewer's yeast during the day.

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## DISINFECTION OF THE SURGEON'S HANDS.

In an article read before the Congress of the German Surgical Society, in April, 1901, Dr. M. Blumberg pointed out that as yet no method has been evolved which assures perfect sterilization of the hands of the surgeon and of the skin of the patient. Bacteriological experiments by the author and by Professors Krœnig, Paul and Sarwey have demonstrated that the most efficient method of disinfection at present attainable, consists in the use of mechanical means (soap, water and brush), followed by washing in a solution of a mercurial salt. Among the latter the bichloride has been most commonly employed, but has the decided disadvantages of roughening the skin, and in the not rare instances of idosyncrasy of producing severe eczema. Moreover, its penetrating power is limited owing to formation of insoluble albuminates of mercury. To obviate these objectionable features a new preparation of mercury, a combination of sulphate of mercury with ethylenediamine, has been introduced under the name of sublamine. This has been subjected to careful bacteriological tests by Blumberg, Kroenig and others, who found it at least equal in antiseptic power to the sublimate. The fact that it is non-irritating to the skin, however, enables it to be used in much higher concentrations than the latter in cases in which the hands have come in contact with virulent infectious material. Owing to the ethylenediamine in its composition, sublamine penetrates more deeply into the epidermis than the sublimate, and therefore produces more thorough disinfection. Aside from these advantages, disinfection with this new agent is more easily carried out, and does not require the expenditure of time demanded by the older and far more complicated methods. Its manner of use is as follows: The hands are first scrubbed for five or ten minutes with soft soap and warm water. After rinsing they are then immersed in a 1 to 300 sublamine solution (three pastilles to one quart of water as warm as possible, and brushed for about five minutes. The skin at the sit of operation is disinfected in a similar manner. The use of alcohol is not required in this method.

*Internat. Jour. of Surgery.*

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## SKIN-GRAFTING WITH CALLUS SHAVINGS, IN BLOOD.

Mary M.; age 60 years; Irish. Diagnosis, ulcer of leg. Patient admitted to hospital March 3, 1902. She had a large varicose ulcer situated over the tibia, about 3½ by 2 inches. This condition had existed for nine years, and during that time in spite of all treatment employed had never entirely healed. It had been skin-grafted in the old way, three times unsuccessfully. At the time of entering the hospital the patient suffered so severely from pain that at times she

would cry out. She was put to bed, secretions regulated, the ulcer cleaned up by means of a dermal curette, and dressed for the first twenty-four hours with a Thiersch pack. On the morning of March 5th, after the surface had been thoroughly cleaned up, a bovinine pure pack was applied and kept wet with the bovinine for twenty-four hours.

On the morning of the 7th, I determined to employ grafts securred from a callus on the small toe, in order to demonstrate the technique of this mode of skin grafting to five visiting physicians. The mode of procedure was as follows: The callus was thoroughly scrubbed up, and the external layers scraped off. Then thin sections of the layers next to the true skin were obtained by means of a very keen razor. Nine of these were deposited on the ulcerous surface. Over these were laid strips of perforated rubber tissue, then strips of plain sterilized gauze saturated in bovinine, and a bandage applied. The nurse was instructed to keep the dressings wet with bovinine pure. This dressing was removed on the 14th, and it was found, much to the delight and astonishment of the visiting physicians, that out of the nine grafts employed eight were firmly adherent and in a healthy growing condition. The ninth had become displaced and was removed. The wound was now dressed with bovinine pure; the dressings being kept wet, and changed once in twenty-four hours. Co-incident with the local dressings, from the outset, the patient had been given a wineglassful of bovinine in milk alternating with wine and beer every three hours. On March 24th she ws discharged cured, the entire surface having become covered with new healthy skin. [illegible]

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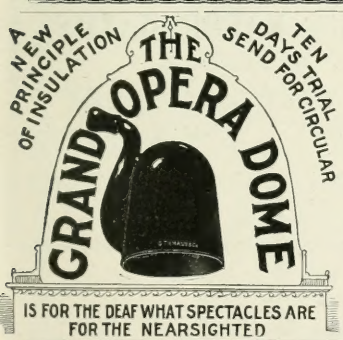
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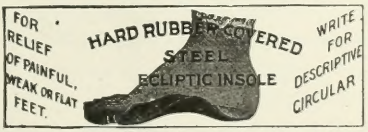


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